

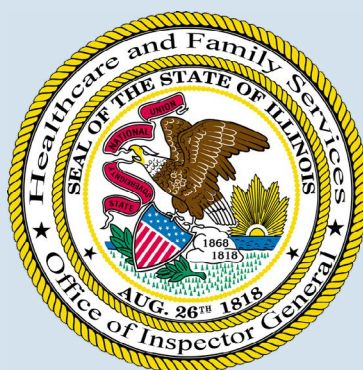


State of Illinois  
Department of Healthcare and Family Services



Office of Inspector General

# Annual Report Fiscal Year 2021



**JB Pritzker, Governor**  
Brian J. Dunn, *Inspector General*



To Governor Pritzker, Senators, Representatives, and the Residents of Illinois:

Enclosed for your review is the annual report for Fiscal Year 2021 for the Office of Inspector General for the Illinois Department of Healthcare and Family Services (OIG).

With my appointment in April 2021, OIG underwent a leadership change near the end of this fiscal year. I thank Patrick Conlon, who remains as the OIG Deputy Inspector General for Operations, for his stewardship while serving as the Acting Inspector General for over a year. I spent the final months of FY2021 and the early months of FY2022 assessing the strengths of this office and identifying opportunities to achieve greater impact with our work.

Unsurprisingly, as in all other aspects of work and life, the Public Health Emergency brought on by COVID-19 has had a considerable effect on OIG operations — presenting numerous challenges but also opportunities. To allow healthcare providers to remain focused on direct care, OIG ceased certain audit activities for part of this year and continued to pause on-site visits. In response to federal and state guidance, provider and recipient eligibility requirements were also loosened. Despite these adjustments, OIG has remained vigilant in identifying and preventing fraud, waste, and abuse in the Illinois Medicaid system and other State-administered federal programs.

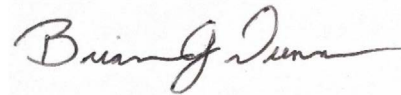
In FY2021, we started to lay the groundwork for transformations that will continue to develop and deliver results over future fiscal years. These initiatives include:

- **Strengthening oversight and collaboration in Medicaid managed care:** Medicaid has undergone a rapid transformation over the last decade with the growing role of Managed Care Organizations (MCOs). In that time, oversight tools and protocols have not kept pace with the change. OIG is developing new reporting mechanisms for Medicaid MCOs related to program-integrity efforts to ensure greater accountability, better collaboration, and a quicker response to fraud concerns.
- **Focusing on return on investment in investigations:** Historically, OIG investigations have focused on fraud by benefit recipients, not by Medicaid providers. This has been, in part, due to limited resources as well as past administrations' prioritization and training. With the transition of Supplemental Nutrition Assistance Program fraud investigations to the Illinois Department of Human Services, the OIG Bureau of Investigations will refocus its efforts on provider-fraud investigations, which promise a more significant impact on the Medicaid system and a higher return on investment. This wide-ranging transformation will require the development of new procedures, systems, and training.

- **Leveraging internal resources and external partnerships:** As this report demonstrates, OIG's mandate encompasses a wide array of activities. As a result of this diverse work, OIG's various bureaus and units were not as integrated in their efforts as they needed to be. Through the implementation of communication protocols, regular meetings, and greater transparency, OIG is able to better coordinate its efforts and ensure the strongest possible outcomes. OIG is also developing the necessary protocols to make sure that its local, state, and federal partners are integrated into its operations.
- **Ensuring the professional development of staff:** Providing consistent and comprehensive opportunities for the continued professional education of OIG staff is imperative to ensure that the office can identify and address the latest fraud trends in the industry. OIG must have a plan to keep the skill sets of its auditors, investigators, attorneys, reviewers, and support staff relevant and sharp. OIG has started monthly sessions for all staff, surveyed needs, offered new trainings, and continues development of an office-wide training plan.

As we look to brighter days with the waning of the pandemic, OIG sets its sights on its strategic path forward with continuous improvement of its oversight and program-integrity efforts in the name of safeguarding tax-payer dollars and ensuring the highest level of care for Medicaid customers. This FY2021 annual report reveals the scope of our efforts and the solid foundation on which we will continue to build.

Respectfully,

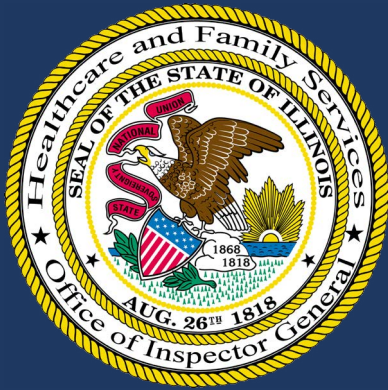
A handwritten signature in black ink, appearing to read "Brian J. Dunn". The signature is fluid and cursive, with a long horizontal line extending from the end.

Brian J. Dunn  
Inspector General

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# OVERVIEW OF HFS OIG



# OIG Mission and Authority

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## ***Mission***

To prevent, detect, and eliminate fraud, waste, abuse, mismanagement, and misconduct in the Illinois Medicaid system.

## ***Authority***

Pursuant to OIG's enabling statute, 305 ILCS 5/12-13.1 *et seq.*, the Office has the following jurisdiction and powers.

## ***Jurisdiction***

Oversight of Healthcare and Family Services (HFS) programs, including the Illinois Medical Assistance Plan (Medicaid), the Illinois Department of Aging's programs, and any programs of the Illinois Department of Human Services (DHS), as established by agreement.

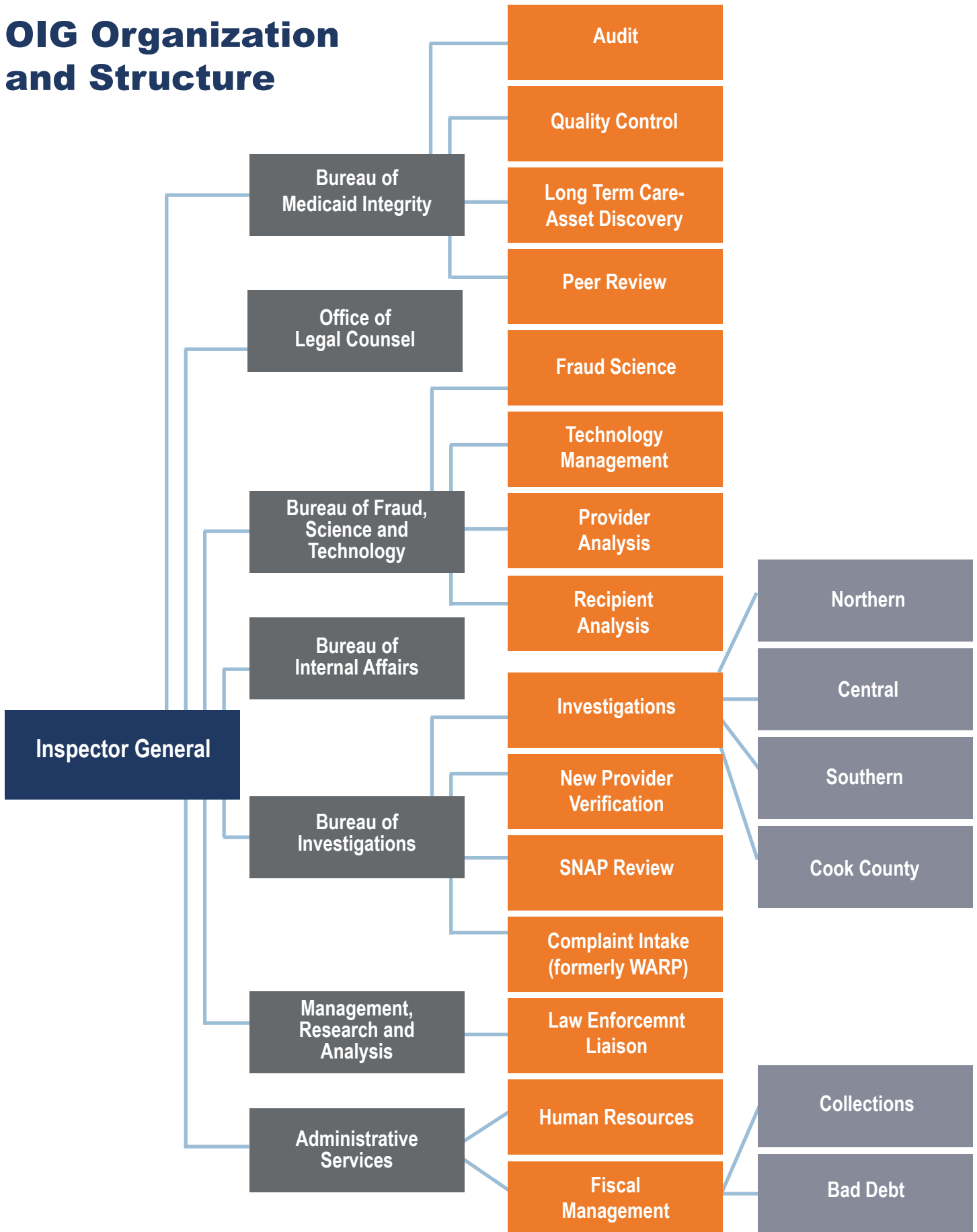
## ***Powers***

1. Investigation of misconduct by employees, vendors, contractors, and medical providers
2. Prepayment and post-payment audits of Medicaid providers
3. Monitoring of quality assurance programs
4. Measuring quality control
5. Investigation of fraud or intentional program violations
6. Initiating actions against contractors, vendors or medical providers for program violations; sanctions by other entities; monetary recoveries or violations of contracts

## ***Additional authority***

7. Access to information necessary to perform duties of the office
8. Data sharing with state and federal authorities
9. Denial and suspension of payment
10. Denial, suspension, or termination of provider enrollment in Medicaid
11. Serving as Illinois Medicaid's primary liaison with law enforcement
12. Subpoena power

# OIG Organization and Structure



## OIG Leadership Team

### Brian Dunn - *Inspector General*

Brian joined OIG in April 2021 after having served for six years as the First Deputy Inspector General and General Counsel for the City of Chicago Office of Inspector General. Prior to that, Brian was General Counsel for the Illinois Department of Human Services (DHS) and the Illinois Department of Commerce and Economic Opportunity, and an Associate General Counsel for the Office of the Governor of Illinois. Before joining public service, Brian worked as a litigation associate for Mayer Brown LLP and clerked for the Honorable James Moran in the U.S. District Court for the Northern District of Illinois.

### Anthony Florio - *Deputy Inspector General of Investigations*

Tony joined OIG in March 2022 after having worked in the City of Chicago's Office of Inspector General Investigations Section for seventeen years. Over that time, Tony worked his way from an Investigator I to a Chief Investigator, leading a team in complex investigations involving comprehensive data analysis, surveillance, extensive interviewing, and high-profile criminal allegations.

### Patrick Conlon - *Deputy Inspector General of Operations*

Patrick joined OIG in December 2016 after having served as the Deputy Director for Administrative Appeals for the Illinois Comptroller's Office for four years. Prior to that, Patrick served the Illinois Treasurer's Office in various capacities, including Legal Counsel and Program Manager. Patrick received a J.D. from Chicago-Kent College of Law and is a Certified Program Integrity Professional by the Medicaid Integrity Institute.

### Nathan Kipp - *Chief Legal Counsel*

Nathan joined OIG in February 2022 after having served nearly half of a decade in offices of inspectors general for City of Chicago sister agencies: first, as an Assistant Inspector General for the Chicago Board of Education, and then as both the Deputy Inspector General and Interim Inspector General for the Chicago Park District. A seasoned litigator, Nathan previously practiced law as a member of the global litigation groups within Mayer Brown LLP and Winston & Strawn LLP, where he handled complex and class-action lawsuits that stemmed from the 2008 financial crisis and conducted internal investigations upon the requests of Fortune 500 Companies' and financial institutions' Boards of Directors. Before entering private practice, he served as a Staff Attorney for the U.S. Court of Appeals for the Seventh Circuit before transitioning to the role of a judicial clerk for the Honorable Michael S. Kanne.



## **Lisa Castillo - Bureau Chief of Medicaid Integrity**

Lisa started with the State of Illinois in 2012, when she joined HFS as an Administrative Law Judge presiding over actions filed by OIG. Prior to becoming Bureau Chief, she worked for the Office of Counsel to the Inspector General (OCIG), litigating cases involving recoupment of overpayments identified by in-house and contractor audits, as well as termination actions against Medicaid-enrolled providers. While at OCIG, Lisa specialized in Recovery Audit Contractor (RAC) audits, litigating cases involving hospital utilization review and medical coding. As part of her RAC specialization, Lisa obtained credentialing from the American Association of Professional Coders in 2019 as a certified medical coder. Lisa's extensive public legal service background also includes practice in criminal law, as she served as an Assistant State's Attorney for Cook County for eight years.

## **Phronsie Spaulding - Assistant Bureau Chief of Medicaid Integrity**

Phronsie joined HFS' Division of Program Integrity (which became the Office of Inspector General in 1994) in September 1988 as a Social Service Career Trainee. This position was responsible for the federally mandated review of claims paid through the Medicaid Management Information System. Phronsie promoted into several positions within OIG and currently oversees the operations of federally mandated audits and eligibility reviews, recipient verification of services, and Long-Term Care - Asset Discovery Investigations.

## **Cindy Daugherty - Manager of Provider and Recipient Analysis Units and Peer Review**

Cindy brings over thirty years of nursing and managerial experience from a variety of healthcare settings, including hospital medical and surgical units, emergency departments, a long-term care psychiatric facility, and outpatient surgical clinics to the OIG team. Cindy joined OIG in February 2016 as the Provider and Recipient Analysis Unit Manager after having worked in the HFS provider billing unit within the Bureau of Professional and Ancillary Services. Cindy became a Certified Professional Coder in 2018. In October 2020, she assumed the role of acting manager of the OIG Peer Review Unit.

## **Clovia Malatare - Manager of the Bureau of Medicaid Integrity Audit Section**

Clovia joined the OIG's Bureau of Medical Quality Assurance (which later became the Bureau of Medicaid Integrity) in June 1996 as a Public Service Administrative Intern. Over that time, she worked her way from Administrative Assistant to Executive I. In September 2019, she became the audit manager for the Bureau of Medicaid Integrity. Prior to joining OIG, Clovia worked for the Illinois Department of Employment Security from May 1991 to October 1993. Clovia was an educator for a private college until her return to state service in 1996.

## **Brian Bond - *Acting Bureau Chief of Investigations***

Brian has been with OIG since September 2012. He assumed his current role as Acting Bureau Chief in March 2021, while continuing to serve as the Supervisor of the Southern Unit for Investigations. Brian has been with HFS since October 1998, serving in various capacities including the Department's State Purchasing Officer. Brian also served in several leadership positions within the Department's Finance division.

## **Joshua Hughes - *Bureau Chief of Internal Affairs***

Joshua joined OIG in November 2018 after serving for five years as an Investigator with the Illinois Office of Executive Inspector General for the Agencies of the Illinois Governor (OEIG). Prior to working for the State of Illinois, Joshua spent a decade within the federal government as a contractual investigator and in operations at the National Security Agency. Joshua is also a veteran of the U.S. Navy.

## **Eddie Escamilla - *Assistant Bureau Chief of Internal Affairs***

Eddie is a graduate of Western Illinois University who joined OIG in June 2020. Prior to the OIG, Eddie spent twelve years working at the Illinois OEIG as a Supervising Investigator and Grant Review Initiative Team Leader. Eddie also spent a decade in law enforcement as a Police Officer, Field Training Officer, Detective, and Lead Hostage Negotiator for the Metro Nashville Police Department and Chicago Police Department. In addition to OIG duties, Eddie is a member of the HFS Diversity Equity and Inclusion Taskforce and the HFS Strategic Planning Taskforce.

## **Wei-Shin Wang - *Bureau Chief of Fraud Science and Technology***

Wei-Shin has worked for HFS for thirty years. Prior to his current OIG position, he served as a Project Director and developed a statewide Medicaid initiative tracking mental health fee-for-service and grant-in-aid providers. From 2007 to 2011, Wei-Shin also served as the Project Manager and Acting Project Director for the Centers for Medicare and Medicaid Services (CMS) Medicaid Transformation Grant. During that time, Wei-Shin successfully led a team to establish the comprehensive, online Dynamic Network Analysis (DNA) system to monitor the services and payments for all Medicaid providers and recipients. CMS' Center for Program Integrity has recognized the use of the DNA system as an industry best practice. Wei-Shin served two terms as chairman of the Statistical Analysis System Central Illinois Users' Group between 2007 and 2009.



## **Steve Bandy - Assistant Bureau Chief of Fraud Science and Technology**

Steve started with HFS in 1987. For the past five years he has served in the OIG's Bureau of Fraud Science and Technology as operational and analytical support to the office and HFS at large. Before joining OIG, he served as analytical support for the implementation of Medicaid's provider enrollment system, IMPACT; managed programs focused on provider reimbursement, unpaid bills, and eligibility issues; started a new unit to provide electronic claim transaction support; was a budget support analyst; and analyzed access to care across the state. Steve also provided SQL and NOMAD programming and support for the Enterprise Data Warehouse and the older mainframe, respectively. While serving with U.S. Air Force, Steve graduated from Southern Illinois University with Bachelor of Science in Industrial Technology and completed an Associate Degree in Radio Communications.

## **Melissa Block - Manager of Management, Research, and Analysis**

Missy joined OIG in November 2013, continuing her career in state government. Prior to OIG, Missy spent over five years with HFS' Provider Enrollment Services, and two years at the Illinois Department of Financial and Professional Regulation. Missy began her state service as a Graduate Public Service Intern for the University of Illinois at Springfield, working as a Recycling and Energy Educator for the Illinois Department of Commerce and Economic Opportunity from 2000-2004.

## **Kimberly Herrington - Human Resources Liaison**

Kimberly joined OIG in September 2019. Previously, she had worked at DHS' Bureau of Recruitment and Selection for fourteen years. Prior to that, she worked in DHS' Human Resources since 1997. Kimberly assists and offers advice to all OIG staff related to Human Resources and Labor Relations.

## **Marsha Eiter - Fiscal Manager**

Marsha joined OIG in February 2013 as the Assistant Bureau Chief of Fraud Science and Technology. Marsha later transitioned to the Bureau of Medicaid Integrity as Audit Manager and then as Assistant Bureau Chief overseeing the Audit and Peer Review Units. Subsequently, Marsha transferred to her current position as Fiscal Manager. Marsha joined the Illinois Department of Public Aid, later HFS, as a budget analyst in 1988. Marsha left state service in 2007 and worked as an IT consultant with the Illinois Department on Aging and OIG for three years. She then worked for United Healthcare as a Senior SAS Programmer and UNIX administrator for three years until joining OIG.

## OIG Bureau Overview

### *Bureau of Medicaid Integrity*

The Bureau of Medicaid Integrity (BMI) is tasked with ensuring program integrity and quality in Illinois's Medical Assistance Program (Medicaid) by detecting fraud, waste, and abuse. BMI's program integrity activities include compliance audits of paid claims, quality-of-care reviews of medical records, and oversight responsibility for audits conducted by federally-mandated, external auditors — the Recovery Audit Contractor (RAC) and the Unified Program Integrity Contractor (UPIC). BMI also verifies with recipients that they received services for which Medicaid was billed, and investigates unallowed asset transfers of those applying for long-term-care medical assistance. BMI is composed of:

- Audit
- Peer Review
- Quality Control
- Recipient Eligibility Verification
- Long Term Care – Asset Discovery Investigations

### *Bureau of Investigations*

The Bureau of Investigations (BOI) provides professional investigative services and support to HFS, DHS, and the Illinois Department on Aging in an effort to prevent, identify, investigate, and eliminate fraud, waste, and abuse in all programs administered by the Departments.

BOI investigates allegations of suspected fraud, waste, and abuse by providers in and recipients of HFS and DHS programs including Medicaid and its waiver programs, SNAP (Supplemental Nutrition Assistance Program), TANF (Temporary Assistance for Needy Families), and the Child Care Program. BOI may refer its investigations to law enforcement for criminal prosecution or to OIG attorneys for administrative sanctions against a provider or recipient. BOI works with state and federal prosecutors, members of the law enforcement community, and other state and federal regulatory agencies. BOI is composed of:

- New Provider Verification and Monitoring
- Complaint Intake (formerly Welfare Abuse Recovery Program)
- Investigations
- SNAP Fraud Unit

### *Bureau of Internal Affairs*

The Bureau of Internal Affairs (BIA) investigates allegations of misconduct by HFS and Illinois Department on Aging employees and contractors, and engages in proactive efforts to identify fraudulent staff activity and security weaknesses. BIA is also responsible for monitoring the security of HFS staff and facilities.

## ***Bureau of Fraud Science and Technology***

The Bureau of Fraud Science and Technology (BFST) is responsible for OIG's introduction, development, and maintenance of new technologies. BFST utilizes these technologies to analyze, detect, and prevent fraud, waste, and abuse by providers and recipients. BFST oversees OIG's Dynamic Network Analysis Predictive Modeling System (DNA), its primary data analytics system, and OIG's Case Administrative System Enquiry (CASE), its case tracking and document-management system. BFST trains OIG staff on these systems and technologies. BFST initiatives center around supporting OIG's mission to ensure program integrity by evaluating and promoting data integrity. BFST is composed of:

- Fraud Science Team (FST)
- Technology Management Unit (TMU)
- Provider and Recipient Analysis Section (PRAS)

## ***Management, Research, and Analysis Section***

The Management, Research, and Analysis Section (MRA) conducts and coordinates complex technical processes that impact healthcare oversight. MRA's coordination occurs internal to OIG connecting the various bureaus and units in collective efforts, and externally with OIG's various partners and stakeholders, including law enforcement and the Managed Care Organizations (MCOs). MRA staff is responsible for reporting findings and making recommendations based on the results from research studies and data analysis to prevent and detect healthcare fraud and to increase efficiency within OIG. MRA is also responsible for evaluating program policies and procedures relating to Medicaid oversight and serves as the OIG liaison with HFS staff to facilitate the work of all OIG bureaus. The MRA Manager is the liaison with the MCOs and oversees the Fraud, Waste, and Abuse Executive (FAE).

## ***Office of Counsel to the Inspector General***

The Office of Counsel to the Inspector General (OCIG) provides legal advice to the Inspector General and OIG leadership, and advocates on behalf of all of OIG's programmatic units. OCIG acts as in house legal counsel, providing legal support for OIG's audits, investigations, inspections, and reviews. OCIG also handles all administrative prosecutions of sanctions against Medicaid providers, including terminations, overpayment recoupments, payment suspensions, and enrollment application denials.

## ***Fiscal Management Unit***

The Fiscal Management Unit oversees all fiscal matters, including general collections, bad debt, procurement, personnel timekeeping, and budget responsibilities. Fiscal Management staff monitors OIG's annual budget and expenditures, and requests additional funds through the budgeting process as needed for special projects and initiatives.

## External Partners

OIG works with a variety of external partners in its effort to prevent and investigate fraud, waste, and abuse in Illinois Medicaid and other federal programs. These partners include other state and federal agencies, external contracted auditors, and public/private associations. Several of OIG's key partnerships are highlighted below.

### State

#### *Medicaid Fraud Control Unit (MFCU)*

Under federal law, states are required to operate a Medicaid Fraud Control Unit, which is tasked with investigating and prosecuting Medicaid provider fraud and abuse or neglect of residents in healthcare facilities. Illinois' MFCU is operated by the Illinois State Police with support from the Office of the Illinois Attorney General. OIG, as HFS' liaison with law enforcement agencies, is statutorily mandated to report suspected Medicaid fraud to MFCU. OIG works with MFCU on active investigations and prosecutions of Medicaid providers, gathering information and data, identifying subject matter experts on policy and programs, and providing witness testimony in criminal and civil proceedings. OIG and MFCU collaborate through both formal and informal communication to ensure that both administrative and criminal proceedings advance without conflict.

#### *Illinois Department of Financial and Professional Regulation (IDFPR)*

Many of the providers enrolled in Medicaid work in professions licensed and regulated by the Illinois Department of Financial and Professional Regulation. To maintain Medicaid enrollment, a provider must hold all required professional licenses in good standing. The suspension or termination of a professional license will result in OIG pursuing a provider's termination from Medicaid. Due to the overlap in OIG's oversight and IDFPR's regulatory jurisdiction, OIG works closely with IDFPR to ensure that the agencies' efforts are coordinated and that each agency is aware of any actions against common providers. OIG and IDFPR share information through referrals, document requests, data reports, and monthly meetings, to maintain high-quality, professional care in Medicaid.

#### *State Agencies Operating Waiver Programs*

DHS and the Illinois Department on Aging have been delegated the day-to-day operations for certain waiver programs under Illinois Medicaid. In this role, these agencies often receive information regarding potential fraud, waste, and abuse in their waiver programs. DHS and the Department on Aging also maintain the expertise on their waiver policies, their network of providers, and their client population. OIG works closely with both agencies and their investigative units on allegations that relate to their waiver programs and associated providers.

## **Federal**

### ***Centers for Medicare and Medicaid Services Center for Program Integrity (CPI)***

The mission of the federal Centers for Medicare and Medicaid Services' (CMS) Center for Program Integrity (CPI) is to detect and combat fraud, waste, and abuse in the Medicare and Medicaid programs. Working in tandem with providers, states, and other stakeholders, CPI supports accurate enrollment and billing practices. OIG's work with CPI includes participating in monthly Technical Advisory Group (TAG) calls with other state partners to discuss topics including fraud schemes, provider enrollment, data analytics and managed care. CPI staff also work with OIG and other states' program-integrity units and the Universal Program Integrity Contractor (UPIC) to provide audit and investigation assistance.

### ***U.S. Department of Health and Human Services Office of Inspector General (HHS OIG)***

The HHS OIG fights fraud, waste, and abuse in Medicare, Medicaid, and various other HHS programs. As HHS OIG's jurisdiction encompasses Medicaid at a national level, it overlaps with OIG's jurisdiction. If HHS OIG's investigations implicate Illinois Medicaid providers, OIG may provide information or support to the investigation. Further, when an HHS OIG investigation results in the federal exclusion of an Illinois Medicaid provider, then OIG takes reciprocal action to terminate that provider from Illinois' Medicaid program.

### ***FBI/DEA/DOJ***

As with the state-level MFCU, OIG supports federal law enforcement agencies including the Federal Bureau of Investigations (FBI), the Drug Enforcement Agency (DEA), and the U.S. Department of Justice (USDOJ) in investigation of Medicaid fraud. OIG primarily serves as the liaison between these entities and the Medicaid program to coordinate data collection and relevant policy research.

## **Contractors**

### ***Unified Program Integrity Contractor (UPIC)***

The UPIC program is a no-cost resource to states' Medicaid agencies established under the Federal Deficit Reduction Act, and authorizes external auditors to monitor and audit potentially fraudulent Medicaid claims as well as identify overpayments made to individuals or entities receiving federal funds. OIG's Bureau of Medicaid Integrity utilizes the UPIC auditor, CoventBridge, to conduct medical reviews, utilization reviews, and reviews of potential fraud. OIG works with UPIC on its audits and takes action in response to its findings, including education, recouping overpayments, and suspending or terminating providers.

### ***Recovery Audit Contractor (RAC)***

Illinois contracts with Health Management Systems-Gainwell, Inc., on a contingency-fee basis to conduct audits of state Medicaid claims for enrolled providers of goods and services under the traditional fee-for-service model. RAC audits identify overpayments and underpayments according to the State of Illinois plan. RAC overpayment determinations are referred to OIG Bureau of Collections or OCIG for any appealable issues.

### ***Public/Private Partnerships***

#### ***National Association for Medicaid Program Integrity (NAMPI)***

The National Association for Medicaid Program Integrity (NAMPI) was formed over thirty-five years ago by officials from various states interested in improving information sharing regarding Medicaid program integrity efforts. Today, the association is composed of professionals from a wide variety of disciplines representing Medicaid programs from all 50 states. Through monthly information sharing sessions, regional meetings, various trainings, and annual conferences, OIG gains and shares information on national trends and prevalent fraud schemes, and provides staff with meaningful educational and training opportunities.

#### ***Healthcare Fraud Prevention Partnership (HFPP)***

The Healthcare Fraud Prevention Partnership (HFPP) is a voluntary public-private partnership that helps detect and prevent healthcare fraud through data and information sharing. Partners include the federal government, state agencies, law enforcement, private health insurance plans, employer organizations, and healthcare anti-fraud associations. OIG is a participating member that uses HFPP's information sharing sessions, whitepapers, and studies to educate staff and develop potential leads for further inquiry.

#### ***National Health Care Anti-Fraud Association (NHCAA)***

The National Health Care Anti-Fraud Association's (NHCAA) mission is to protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution, and prevention of healthcare fraud and abuse. OIG participates in NHCAA to further develop staff skills and access information on national trends.

## Managed Care Organizations (MCOs)

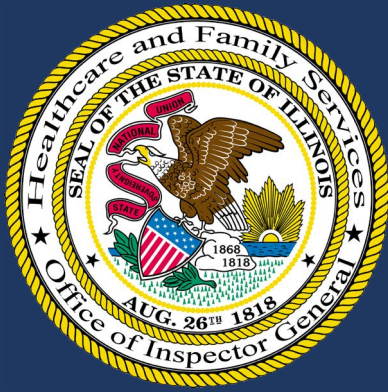
HFS's mission includes improving the health of Medicaid recipients by providing access to, and coordination of, quality healthcare. Pursuant to the Illinois' Medicaid reform law and Save Medicaid Access and Resources Together Act, along with the federal Affordable Care Act, Illinois contracts with health-insurance companies to provide healthcare services to Medicaid recipients. Under this managed care model, Medicaid recipients enroll with a Managed Care Organization (MCO). The MCOs must create comprehensive networks of care, including primary and behavioral health care providers, hospitals, and specialists. The MCOs must ensure continuity of care to their Medicaid customers through a Primary Care Provider and offer care coordination to help participants with complex healthcare needs.

Beginning January 1, 2018, Illinois transitioned its managed-care program into a more streamlined, accountable, and integrated program, HealthChoice Illinois (HCI). The goal of HCI is to provide enhanced quality and improved outcomes at a sustainable cost. Currently, there are four MCOs contracted to provide services statewide. Six MCOs that operate in Cook County also contract with plans to implement (1) the YouthCare Program in conjunction with the Illinois Department of Children and Family Services, and (2) the Medicare Medicaid Alignment Initiative (MMAI) program for those recipients eligible for both Medicare and Medicaid benefits. In FY2021, the six companies providing services under one of the three contracts with HFS were Aetna Better Health of Illinois, Blue Cross Community Health Plans, CountyCare Health Plan, Humana, Meridian Health, and Molina Healthcare.

OIG works collaboratively with the MCOs on their program-integrity efforts. The MCOs are statutorily and contractually required to have dedicated fraud, waste, and abuse staff to investigate and prevent fraud in the Medicaid program. OIG monitors the work and outcomes of the MCOs' Special Investigations Units through regular reporting and the review of fraud referrals. OIG meets monthly with the investigative teams to coordinate efforts, identify trends, and discuss findings.

## Important Links

- Complaint Portal [Report Fraud | HFS \(illinois.gov\)](#)
- HFS OIG Medicaid Exclusion List [Provider Sanctions Search | HFS \(illinois.gov\)](#)
- Website [Office of Inspector General Home | HFS \(illinois.gov\)](#)



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# **ACTIVITIES AND IMPACT IN FISCAL YEAR 2021**

# Financial Impact

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## OIG Officewide

### Dollars Recovered

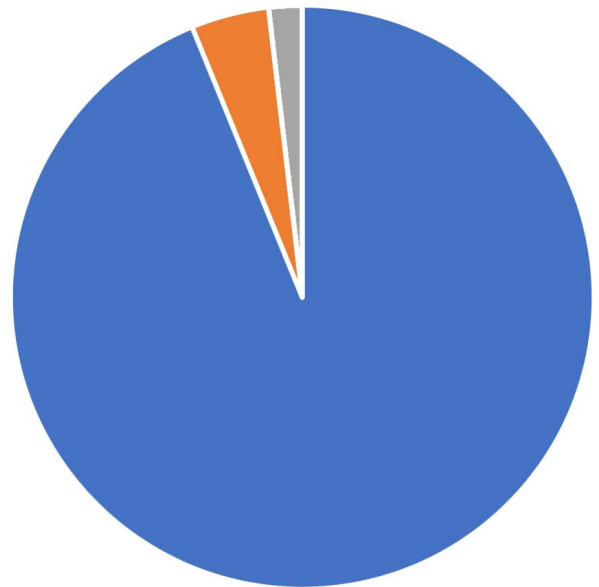
Dollars recovered are overpayments that have been **collected** based on the results of an investigation, audit, inspection, or review. Dollars recovered would first have been calculated as an overpayment identified in Questioned Costs, either from this fiscal year or a prior fiscal year.

**Total: \$13,441,726**

**Provider Audits: \$12,613,692**

**Global Settlements: \$578,421**

**Restitution: \$249,613**



### Questioned Costs

Questioned costs include **overpayments identified for recovery** during an OIG investigation, audit, or review due to an alleged violation of a statute, law, regulation, rule, policy, or other authority governing the expenditure of funds.

**Total: \$23,830,110**

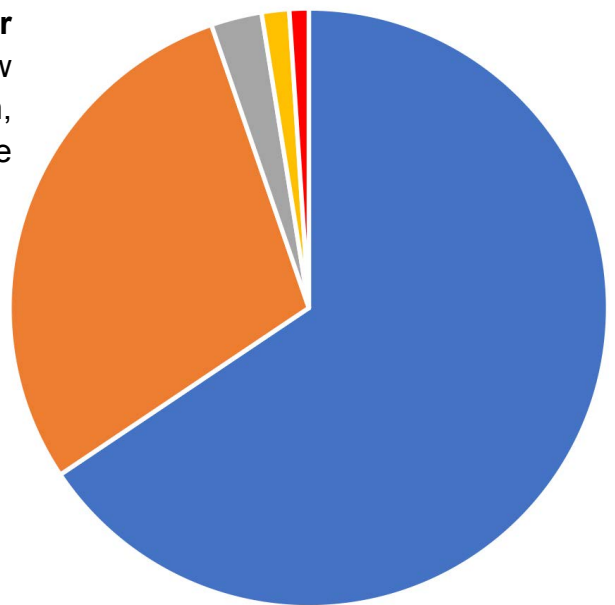
**Provider Audits: \$15,650,206**

**Client Eligibility: \$6,947,270**

**SNAP: \$655,954**

**Childcare: \$354,614**

**Restitution: \$249,613**



## Funds Put to Better Use

Funds put to better use are those which were not expended after identifying that the operational, medical, contract or grant expense was unnecessary. These measures align with those used by the federal Government Accountability Office.

**Total: \$17,492,551**

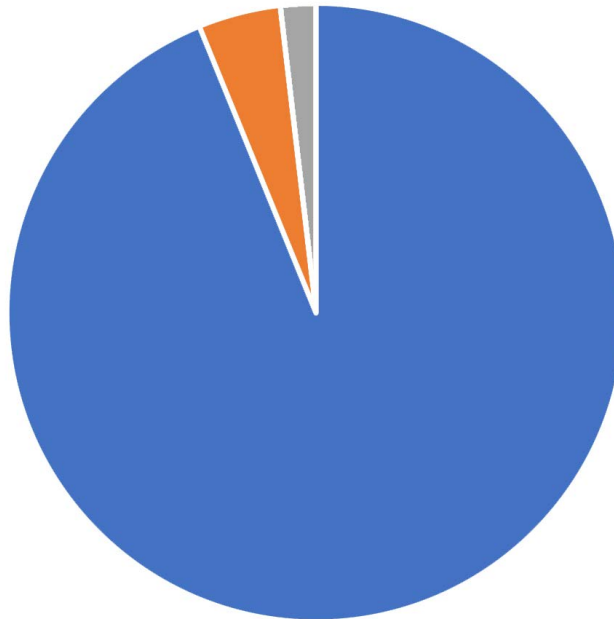
**Provider Sanctions: \$15,339,965**

**Recipient Restriction Program: \$1,462,941**

**SNAP: \$468,210**

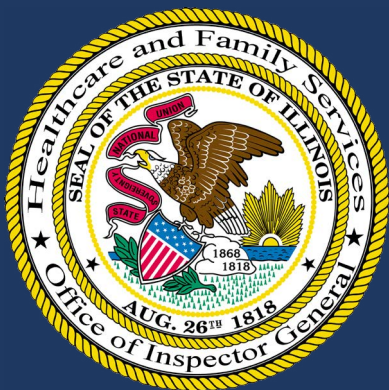
**Client Overpayments: \$221,435**

**LTC-ADI: 0<sup>1</sup>**



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<sup>1</sup> During this fiscal year, HFS suspended the resource test for long-term-care applicants due to the Public Health Emergency. Accordingly, OIG was unable to process any penalties or resource spenddowns. As part of its Long-Term Care Asset-Discovery-Investigations, OIG continued to review applications referred to this office to make preliminary eligibility findings, but no savings could be realized.



Annual Report FY2021

# **BUREAU OF MEDICAID INTEGRITY (BMI)**

## Audits

The Audit Section under the Bureau of Medicaid Integrity strives to maintain the program integrity of the HFS's Medicaid programs through targeted audits for all providers enrolled in the Medical Assistance Program. These audits evaluate provider compliance with state and federal law and Department policy to ensure that improper payments of Medicaid monies are identified and recouped. BMI audits hospitals, pharmacies, nursing homes, laboratories, physicians, transportation providers, and durable medical equipment suppliers. A Medicaid provider may also submit to a self-disclosure audit as the result of the provider's own investigations and review of their billing practices.

The Audit Section also has oversight responsibility for the federally mandated Recovery Audit Contractor (RAC) and the federally authorized Unified Program Integrity Contractors (UPIC). The RAC reviews fee for-service paid claims for compliance with state rules and regulations. The UPIC conducts investigations and audits in an effort to reduce fraud, waste, and abuse in the Medicaid programs.

Both the audits conducted by BMI and by the contracted auditors may result in the recoupment of identified overpayments, entry into a Corporate Integrity Agreement, termination from Medicaid, or referral to the Medicaid Fraud Control Unit (MFCU) for prosecution.

## 2021 Highlights

**Certified Public Accountant (CPA) Audits:** Most of the audits BMI completed in FY2021 were CPA audits of long-term-care facilities. These audits are routine financial audits that establish non-extrapolated overpayments. For FY2021, the average overpayment identified by the CPA audits was just under \$150,000. Two CPA long-term care audits had unusually large recoupment amounts that stemmed from prior credit balances. One audit (#1336440) identified a \$1,152,092 overpayment and another (#1330580) identified a \$649,684 overpayment.

**Electronic Health Records (EHR) Review:** In 2011, CMS established EHR incentives for Medicare and Medicaid providers (now called the "Medicaid Promoting Interoperability Program") to encourage the adoption, implementation, upgrading, and demonstration of meaningful use of certified electronic health record technology. OIG is tasked with ensuring EHR compliance by auditing providers who took advantage of these incentives to upgrade their electronic systems. Illinois receives a 90% federal match on employee salaries to conduct these EHR compliance audits. For FY2021, OIG completed 209 EHR audits and received \$146,029.94 in federal financial participation (FFP).

**Provider Self-disclosures:** The federal Patient Protection and Affordable Care Act (ACA) requires providers to timely identify and repay Medicaid overpayments. Under the ACA, providers are obligated to report, explain, and repay overpayments within sixty calendar days of identification. OIG monitors a self-disclosure protocol that allows providers to voluntarily refer such overpayments upon detection to avoid penalties and sanctions. Although there was a pause in audits due to the Public Health Emergency, providers consistently utilized this protocol to

report self-identified overpayments. Providers identified and repaid approximately \$888,931.58 to the Department through self-disclosure. Some highlights are as follows:

**Lack of Documentation (#1359526):** OIG recouped \$385,210, after a provider conducted a review of their paid claims and disclosed that they were paid for claims that lacked the documentation to support the items that were billed and sold to the plan members.

**Employee Discrepancies (#1365913):** OIG recouped \$201,499 after a provider conducted an internal review of their Assertive Community Treatment program (for mental health services) and identified discrepancies in one employee's hours worked, mileage reported, and services billed.

**Inappropriate Billing Rates (#1362486):** OIG recouped \$146,707.92 after a provider conducted a review of 27 of its dialysis clinics. The provider found that the amount billed by their plan exceeded the contractual allowances or established fee schedules.

## **2021 Statistics**

***New Audits Initiated: 640***

***Audits Completed: 329***

Electronic Health Records: **209**

CPA Long Term Care Audit Review: **71**

Self-disclosure: **33**

UPIC: **5**

Global Billing: **5**

Physician: **1**

Special Project: **1**

Pharmacy: **1**

Transportation: **3**

***Overpayments Identified<sup>2</sup>: \$11,098,415.72***

CPA Long-Term Care Audits: **\$5,451,741.35**

UPIC: **\$4,841,646.31**

Self-disclosures: **\$760,705.69**

In-house Long-Term Care: **\$35,570.19**

Global Billing: **\$4,481.71**

Special Project: **\$2,132.74**

Transportation: **\$1,495.01**

Physician: **\$667.72**

***Payment Agreements Entered: 47***

***Audits Sent for Legal Action: 5***

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<sup>2</sup> This represents the overpayment amount that the Audit section identified as a result of its audit. The actual amount established as an account receivable may be different as the result of negotiation, settlement, or an administrative hearing. The amount that OIG collects may be different from both Audit's identified overpayment and the established account receivable if the provider fails to pay its debt.

## Peer Review

The Peer Review Unit (PRU) consists of nurses and physicians tasked with conducting utilization and quality-of-care reviews of healthcare furnished to Medicaid recipients by providers such as physicians, dentists, podiatrists, audiologists, chiropractors, nurse practitioners, and optometrists. Quality-of-care concerns are risk of harm, medically unnecessary care, and grossly inferior quality of care. Risk of harm is identified when there is a risk to the patient that outweighs the potential benefit of the service. Medically unnecessary care is identified when the care provided to the patient is not needed and/or exceeds the patient's needs. Grossly inferior quality of care is identified when flagrantly poor care is provided to a patient. PRU cases originate from hotline complaints, internal referrals, or external agencies such as the Illinois Department of Financial Professional Regulation, the Illinois Department of Public Health, Illinois State Police, or MCOs.

After utilization and quality-of-care reviews, PRU may recommend case closure when minor or no deficiencies are found. PRU refers cases to an OIG physician consultant when potentially serious concerns are identified. If the physician consultant identified only minor concerns, PRU may issue a letter to the provider that outlines its quality-of-care concerns and corrective-action recommendations. For more serious quality-of-care concerns by the physician consultant, PRU may refer the provider to the Medical Quality Review Committee (MQRC) to review and discuss the identified concerns. The MQRC consists of OIG staff and OIG medical consultants of same specialty. The MQRC will make a recommendation to OIG to close the matter; send a letter to the provider identifying its concerns; require the provider to implement corrective action within a certain time period; refer the matter internally or externally for further action; or recommend administrative action, such as termination, entry of a corporate integrity agreement, suspension, or denial of reinstatement or enrollment.

PRU also conducts a quality-of-care review for any providers that submit an enrollment application and were previously terminated, suspended, or withdrew from the Medicaid Program, or had an action/discipline noted on their license.

## 2021 Highlights

**Opioid Prescription Monitoring:** Battling the opioid crisis is a top priority in America and presents an urgent quality-of-care concern with OIG. PRU scrutinizes physicians that are allegedly overprescribing opioids or prescribing without the proper safety nets. PRU and IDFP work collaboratively on the review of physician medical records to address quality of care and over-utilization of services. In FY2021, there were two cases that resulted in IDFP and PRU action:

**Internal-Medicine Physician (OIG #1333209):** In this case, a pharmacist alerted IDFP that a physician had been suspected of overprescribing opioids. IDFP entered into a consent order with the doctor in May 2020. As a result of this consent order, PRU conducted a review of the provider's patient care from 2016 through 2018. PRU sent the physician a letter of concern in May 2021, requiring immediate corrective action. PRU's letter addressed concerns such as insufficient documentation, failure to order testing and screenings, and the failure to follow the HFS handbook. PRU also referred the provider to OIG Audit to review medical records compliance and whether billings are supported by medical documentation.

**Family-Practice Physician (OIG #1217088):** PRU performed a review of the provider and identified that he had overprescribed opioids, failed to check Illinois' prescription monitoring program, did not seek out alternative treatments, and failed to evaluate the patients with screening methods such as urine drug tests. As a result, PRU sent the provider a letter of concern. In turn, IDFPR reviewed this physician's drug-prescription utilization in 2020. This review resulted in the suspension of the provider's medical license and entry into a consent order. PRU conducted another review to verify the provider's adherence to the consent order and issued another letter of education in June 2021, which recommended completion of continuing medical education on pain-management and health-maintenance documentation.

**Procedures for Remote MQRC Reviews:** In FY2021, PRU, in conjunction with OCIG, began the process of developing policies and procedures to conduct MQRC reviews remotely. MQRC reviews have been on hold since the start of the Public Health Emergency. Once completed these new procedures will allow the option of holding MQRCs remotely, creating efficiency and cost savings for this oversight activity.

## 2021 Statistics

### Cases Reviewed: 44

Quality-of-Care Reviews: **21**  
Enrollment Application Reviews: **16**  
Re-instatement Reviews: **5**  
Re-enrollment Reviews: **2**

### Case Review Outcomes:

#### Quality-of-Care Review Outcomes

Letter of Concern: **8**  
Medical Quality Review Committee (MQRC) referral: **3**  
Closed Based on Inactive Provider Status: **3**  
Letter of Education: **2**  
Referrals to OCIG for Corporate Integrity Agreements: **2**  
Letter with No Concern: **1**  
Corrective-Action Plan: **1**  
Referral for Audit: **1**

#### Enrollment Application Review Outcomes

Approved: **15**  
Denied: **1**

#### Re-instatement/Re-enrollment Review Outcomes

Approved: **7**  
Denied: **0**  
MQRC Conducted: **3**

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<sup>2</sup> This represents the overpayment amount that the Audit section identified as a result of its audit. The actual amount established as an account receivable may be different as the result of negotiation, settlement, or an administrative hearing. The amount that OIG collects may be different from both Audit's identified overpayment and the established account receivable if the provider fails to pay its debt.

## Quality-Control Review

Quality-Control Review (QC)/Central-Analysis Section (CAS) oversees the federally mandated Medicaid Eligibility Quality Control (MEQC) program and the Payment Error Rate Measurement (PERM) initiative. The MEQC program focuses on improving the quality and accuracy of Illinois' Medicaid and Children's Health Insurance Program (CHIP) eligibility determinations through annual reviews. The MEQC program is intended to complement the PERM program by ensuring state operations make accurate and timely eligibility determinations so that Medicaid and CHIP services are appropriately provided to eligible individuals. The PERM program measures improper payments in Medicaid and CHIP and produces error rates for each program. The PERM is conducted every three years. QC conducts the eligibility reviews for MEQC and aids the federal auditors for PERM. CAS is responsible for the coordination of the completion of questionnaires, on-site reviews, and systems access and identification of the universe of claims for federally contracted auditors. CAS also acts as the liaison between the Department's staff responsible for the payment of claims and the federal auditors. In addition, CAS coordinates the development of, and monitors, corrective-action plans designed to eliminate or reduce errors utilizing various methods, including training, system programming, and policy changes.

### 2021 Highlights

**Medicaid Eligibility Quality Control 2020 Corrective-Action Plan (CAP):** During FY2021, QC finalized and received approval from CMS on the MEQC CAP. This CAP required a state-wide implementation of HFS and DHS caseworker training on those areas cited as errors or deficiencies in the MEQC 2020 reviews. This training was a collaboration between QC, HFS, and DHS. QC initiated and provided the content for the training. DHS created the training, and both HFS and DHS administered the training to their caseworkers. QC monitored and ensured the completion of the training.

**Illinois Residency Verification Review:** In FY2021, QC initiated a special project to identify apparent recipients who no longer reside in Illinois. A total of 610 cases were reviewed, with 215 resulting in unverified addresses. These cases resulted in a cost avoidance of \$555,574.04. The cost avoidance for each apparent recipient is calculated by adding four months of managed-care capitation payments that would have been paid if not for the verification.

### 2021 Statistics

#### ***Total Cases Reviewed: 703***

Illinois Residency Review: **610**

PERM RY22: **69**

MEQC 2020: **24**

## Long-Term Care – Asset-Discovery Investigations

Long-Term Care – Asset Discovery Investigations (LTC-ADI) conducts reviews of long-term-care applications triggered by specified criteria related to the transfer and disclosure of assets. Undisclosed assets or those transferred for less than fair market value result in penalty periods where the recipient will be ineligible to receive Medicaid payments. During these penalty periods, the recipient is liable for the LTC expenditures at a private pay rate. LTC-ADI reviews trust documents to determine if they meet current policy requirements. By preventing improper conduct related to eligibility, LTC-ADI ensures program funds go to qualified applicants who have no other means to pay for their own care. Adverse determinations may be appealed in an administrative-hearing process. This section manages LTC applicant appeals for asset determinations. Once all appeals are exhausted, the final determination regarding LTC eligibility is implemented by the local DHS Family Community Resource Center.

### 2021 Highlights

**Eligibility Waivers Due to the Public Health Emergency:** During FY2021, the resource test for long term care applicants was suspended due to the Public Health Emergency. Accordingly, OIG was unable to process any penalties or resource spenddowns during the Public Health Emergency. LTC-ADI continued to review applications referred to OIG to make preliminary eligibility findings. OIG intends to use these findings to determine actual eligibility at the end of the Public Health Emergency when the penalties and spenddowns can be imposed. In FY2021, OIG prepared recommendations on 178 cases to be implemented upon the expiration of the Public Health Emergency. In these cases, OIG identified \$8 million in excess resources and \$10.4 million in unallowable transfers.

**Case Backlog Reduction:** As case referrals decreased in FY2021 due to the Public Health Emergency, LTC-ADI had the opportunity to close out all backlogged cases. These include 1,276 cases that would have amounted to \$22.0 million in unallowable transfers and \$22.4 million in excess resources. Cost avoidance for this time frame would have been \$29.5 million.

**Penalty Period for Transfer of House:** DHS's Bureau of Hearings (BOH) upheld OIG's decision to impose a penalty period for an applicant who made property transfers for less than fair market value. After review of the application, OIG determined that the applicant had transferred real property to her two stepdaughters without receiving anything of comparable value in return. Therefore, OIG imposed a penalty in the amount of \$86,010 based on the property's tax-assessed value at the time of transfer. The applicant argued that the property was not worth the tax-assessed value but was unable to produce any evidence supporting that assertion. In the final administrative decision, BOH found that OIG had presented the only credible evidence of the property's value. Accordingly, BOH upheld the penalty in the amount of \$86,010.

**Penalty Period for Transfer of Cash:** BOH upheld OIG's decision to impose a penalty period for an applicant who made transfers for less than fair market value. After review of the application, OIG found that applicant had made several large transfers to her children from her checking account, for which no evidence of the receipt of fair market value was provided. Accordingly, OIG imposed a penalty in the amount of \$24,491. Applicant argued that these transfers were

reimbursement to the applicant's children for various goods and services provided. However, the applicant was unable to produce any documentation supporting this assertion. In the final administrative decision upholding the penalty, BOH found that the applicant had failed to provide any evidence that applicant received fair market value for the transfers, and therefore failed to overcome the presumption that transfers were made for less than fair market value.

**Partial Denial of Hardship Waiver Following House Transfer:** BOH upheld OIG's decision to partially deny an application for hardship waiver. The applicant had transferred their house to their son (who is deceased) and daughter (who is alive). After review of the application for hardship waiver, OIG found that the applicant had provided a notice of involuntary discharge and documentation that their son was deceased, but provided no evidence that the applicant's daughter was unable to repay the applicant for the transfer of their home. Additionally, the applicant had failed to show that the individual to whom the applicant had granted power of attorney was unable to return the funds received from the applicant shortly before the application for medical assistance. Accordingly, OIG granted the hardship waiver with respect to the deceased son's share from the transferred property, but upheld the penalty with respect to the daughter's share and the funds transferred to the power of attorney. The applicant argued that they had no legal or equitable means to recover the transferred property. In the final administrative decision, BOH found that the applicant had failed to provide any objective evidence to support their assertion that no legal or equitable means were available to recover the transferred property. Accordingly, it upheld the denial of the hardship waiver and remaining penalty in the amount of \$61,054.

**Spenddown for Farmland:** BOH upheld OIG's decision to impose a resource spenddown. After review of their application, OIG determined that an applicant was the owner of farmland, contiguous to their former home, worth \$419,802. OIG concluded this farmland and attached home should be considered an available resource and not be exempt as a homestead because the applicant stated that he resided in his car. The applicant provided an appraisal of the property and valued it at \$280,125, and argued that the property should be exempt because the applicant resided in his car on the property prior to his nursing home admission. OIG agreed to lower the value of the property based on the appraisal but asserted that the property should not be considered an exempt homestead. In the final administrative decision, BOH found that applicant did reside in his vehicle, which could not be considered an exempt homestead, and therefore found the farmland to be an available resource. The final administrative decision upheld the \$280,125 spenddown.

**Continued Impact of *Perlstein v. Dimas*, 2019 Ill. App. 181538 (1st Dist. 2019):** LTC-ADI's asset transfer reviews include those made pursuant to a dissolution of marriage judgment. Specifically, OIG determined that the transfer of assets pursuant to a divorce four months before the application of LTC Medicaid benefits was for less than fair market value, and therefore imposed a penalty period. This decision was appealed and, in 2019, the Illinois Appellate Court for the First District reviewed this issue in its decision *Pearlstein v. Dimas*. In *Pearlstein*, the appellant argued that the Department's administrative code that addresses fair market value is vague and, therefore, unenforceable. In an unpublished order, the Court rejected the argument and held that the administrative code is "clear that the Medicaid penalty applies to all transfers of

assets for less than fair market value within the look-back period, which would necessarily also include transfers of assets made pursuant to a dissolution judgment/MSA [marriage settlement agreement].” The *Pearlstein* decision guided OIG’s asset reviews throughout FY2021 and further serves as persuasive authority in support of an OIG decision that is currently pending appeal.

## 2021 Statistics<sup>4</sup>

***Applications Reviewed: 1,454***

***Applications Returned with Recommendations: 1,276***

Value of Excess Resources: **\$24,426,978**

Value of Unallowable Transfers: **\$22,017,925**

No Spenddown or Penalty: **296**

Denial of Eligibility: **290**

Spenddown Only: **271**

Penalty and Spenddown Recommendation: **223**

Penalty Only: **196**

***Applications Held By LTC-ADI with Recommendations: 178***

Value of Unallowable Transfers: **\$10,444,582**

Value of Excess Resources: **\$8,038,925**

Penalty and Spenddown Recommendation: **59**

Penalty Only: **52**

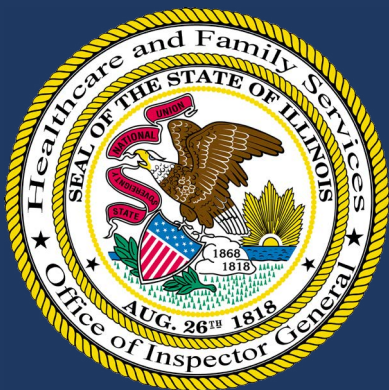
Spenddown Only: **35**

Insufficient Information from Recipient: **32**

OIG serves as the program integrity lead for the Illinois Medicaid program, which covered 3.4 million enrollees and spent \$26.3 billion on benefits and related services in FY2021.

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<sup>4</sup> Due to the Public Health Emergency, the number of applications referred to OIG for review has been greatly reduced as eligibility requirements have been suspended. LTC-ADI has continued its review of referred applications and has returned the majority of those recommendations to the Illinois Department of Human Services. Findings regarding ineligibility, excess assets, and unallowable transfers have not been acted upon due to the Public Health Emergency, so none of the savings identified have been realized. LTC-ADI held its recommendations on 178 applications with the expectation that, once the Public Health Emergency ends, the Department will impose the appropriate spenddown or penalty in response to OIG’s recommendation.



Annual Report FY2021

# **BUREAU OF INVESTIGATIONS (BOI)**

## Complaint Intake Unit

BOI's Complaint Intake Unit serves as the central fraud intake unit for OIG. Complaint Intake processes fraud and abuse referrals received from MCOs, local DHS offices, members of the public, and other stakeholders, alleging potential fraud by Medicaid providers and recipients. Referrals are processed via phone hotline and online intake referral sites, as well as through direct communication with state and federal agencies and law enforcement entities.

The Complaint Intake Unit conducts thorough research on fraud allegations by accessing multiple databases from a variety of sources, including DHS, the Illinois Secretary of State, the Illinois State Police, the Illinois Department of Public Health, the Illinois Department of Employment Security, and the Illinois Division of Child Support Services. OIG determines whether further action should be taken based on Complaint Intake's initial investigation and review of allegations.

## 2021 Highlights

**Complaint Intake Unit Development:** The Complaint Intake Unit was previously known as the Welfare Abuse Recovery Program (WARP) and was more narrowly tailored to processing complaints alleging fraud by recipients of state and federal benefits. Starting in FY2021, the unit transformed its role within OIG, expanding the scope of its intake processes to include all allegations received by OIG.

**Allegations Substantiated:** The Complaint Intake Unit has the ability to substantiate the allegations underlying some complaints through its own investigation. In such cases, it is unnecessary to refer the matter to the Investigations section for further review. In FY2021, Complaint Intake staff substantiated 80 cases through its own research and analysis and was able to refer those cases directly to the DHS Bureau of Collections for further action.

## 2021 Statistics

**Complaints Received: 5,206**

**Complaints Processed: 3,381**

Complaints Closed Due to Insufficient Evidence: **2097**

Complaints Closed Administratively (Duplicate complaint, etc.): **538**

Complaints Referred for Client Eligibility Investigations: **523**

Complaints Referred for Provider (Personal Assistant) Investigations: **141**

Complaints Substantiated and Referred to DHS Collections: **82**

**Responses to Law Enforcement Inquiries: 496**

**Recipient Program Overpayments Referred for Collection: \$221,435**

SNAP: **\$201,356**

TANF: **\$20,079**

## Investigations

BOI's Investigations Section is divided into four units – Southern, Central, Northern, and Cook County. This section conducts investigations into fraud, waste, and abuse in programs administered by HFS and DHS. Historically, BOI focused its investigations on allegations of suspected fraud by recipients of federal benefits. However, during FY 2021, the Bureau began a transition to re-focus resources on the investigation of fraud, waste, and abuse by Medicaid providers. In its investigations, BOI may work with the State Police's Medicaid Fraud Control Unit, state and federal prosecutors, members of the law enforcement community, and other state and federal regulatory agencies. As the result of BOI's investigation against a provider, OIG may refer the matter for criminal prosecution or seek administrative sanctions through its legal office. BOI also continues to investigate recipients alleged to have engaged in eligibility fraud or abuse of their benefits in the Medicaid program, SNAP, TANF, and Child Care Program. These investigations may result in the identification of overpayments, termination of benefits, or prosecution by state and federal agencies. BOI is currently involved in a transition of SNAP fraud investigations to DHS, the agency responsible for administering SNAP.

## 2021 Highlights

**Expanding Focus to Include Provider Investigations:** OIG's Bureau of Investigations was historically focused on eligibility investigations involving recipients of state-administered, federal benefit programs. In FY2021, BOI began the process of expanding its focus to include the investigation of fraud, waste, and abuse allegations against Medicaid providers. As these cases are generally more complex, technical, and resource-intensive, this transition will involve training and the development of new policies and procedures. As a part of this realignment, BOI is of transitioning responsibility for recipient investigations involving SNAP to DHS, which administers that program.

### Significant Criminal Investigations

**Recipient Convicted for Failure to Report Spouse in the Home (Case No. 1286250):** OIG conducted a joint investigation with Chicago Housing Authority OIG (CHA OIG) into a DHS assistance recipient and her landlord in the CHA Housing Choice Voucher Program. The recipient resided at her landlord's residence while she received CHA vouchers, and further failed to report to DHS and CHA that she later married and had a child with him. The landlord, in turn, failed to report their relationship to CHA and continued to collect CHA rental payments for his wife. DHS had a resulting SNAP loss of \$40,251 and CHA had a loss of \$87,333. The Cook County State's Attorney indicted both individuals, and each pleaded guilty to theft. The court sentenced each to three years of second-chance probation and ordered them to pay \$15,000 in restitution, with the remaining amounts due before the completion of their probation terms.

**Recipient Convicted of Falsifying Her Household Composition (Case No. 1315740):** OIG investigated an anonymous complaint against a DHS recipient who had failed to report her true household composition and income. Specifically, the recipient had failed to report that her husband and father of her children was gainfully employed while residing at the assistance unit home. The recipient's failure to report allowed her to receive \$17,693 in public assistance to which she was not entitled. In August 2020, the recipient pleaded guilty to theft. She was later

sentenced to eighteen months of court supervision and ordered to pay \$17,693 in restitution to DHS.

**Recipient Convicted of Falsifying Information to Receive Benefits (Case No. 1324198):**

OIG determined that a DHS recipient had failed to report that the father of her children was gainfully employed while residing at the assistance unit home. The recipient's failure to report her true household composition and income allowed her to receive \$10,492 in public assistance to which she was not entitled. In January 2020, the recipient was convicted of theft, sentenced to twenty-four months of court supervision, and ordered to pay \$9,421 in restitution to DHS.

**Theft of Social Security Benefits (Case No. 1322927):**

The U.S. Social Security Administration's OIG (SSA OIG) contacted HFS OIG regarding a public-assistance recipient who was suspected of having defrauded the Social Security and SNAP programs. The ensuing investigation revealed that the recipient had fraudulently received her father's Social Security benefits after his death, failed to report this income to the DHS office, and further failed to report her husband's income. As a result the recipient received a \$1,640 overpayment of SNAP benefits. HFS OIG referred the SNAP fraud to the U.S. Attorney's Office for the Northern District of Illinois, which criminally charged the recipient. The recipient subsequently pleaded guilty to one count of theft of government property, was sentenced to two years of probation, and ordered to pay restitution in the amounts of \$37,908 to the Social Security Administration and \$1,640 to DHS.

**Childcare Provider Billed Services not Rendered (Case No. 1286231):** OIG conducted a joint investigation with CHA OIG and concluded that a childcare provider who resided in CHA housing billed for, and received payments for, \$209,226 in childcare services that she did not provide by splitting her state payments with her purported clients. The investigation also revealed that the provider had failed to report her supposed business to CHA and her resulting income to CHA and DHS. OIG referred the matter to the Bureau of Child Care Development for further action.

## Significant Client Eligibility Investigations

**Failure To Report Responsible Relative (Case No. 1344983):** OIG concluded that a SNAP recipient incorrectly reported that a responsible relative no longer resided in her home when, in fact, the relative continued to reside in it. DHS Bureau of Collections calculated that, as a result, the recipient received \$60,205 in SNAP overpayments for the period of February 2014 to December 2020.

**Failure To Report Responsible Relative (Case No. 1235921):** OIG concluded that a SNAP recipient incorrectly reported that a responsible relative no longer resided in her home when, in fact, the relative continued to reside in it and collected income from employment. DHS Bureau of Collections calculated that, as a result, the recipient received \$56,825 in SNAP overpayments for the period of January 2013 through July 2020.

**Childcare Recipient Fraudulently Received Benefits (Case No. 1356379):** OIG concluded that, from October 2016 through July 2020, a recipient of childcare assistance had failed to report that the father of her youngest child had resided in her assistance unit, and further collected

unreported employment income and unemployment benefits, resulting in an overpayment of \$25,850.93 in childcare-assistance benefits. OIG referred the matter to the DHS Bureau of Child Care Development.

**Failure To Report Father in Household (Case No. 1323012):** OIG conducted an eligibility investigation and found that, from June 2013 through November 2020, a SNAP recipient had failed to report that the father of her children was a part her household and earned wages. As a result, the recipient received an overpayment of \$46,433 in SNAP benefits.

**Fraud Using Two Social Security Numbers (Case No. 1322007):** While conducting an eligibility investigation, OIG determined that a SNAP recipient had been issued two Social Security numbers and that, from September 2014 through August 2020, the recipient had used one number for work purposes and the other to receive SNAP benefits from DHS. The recipient also failed to report the related income to DHS. As a result, the recipient had received an overpayment of \$22,130 in SNAP benefits, and \$2,406 in grant benefits.

**Failure To Report Spouse and Location of Children (Case No. 1322057):** OIG conducted an eligibility investigation and found that a SNAP recipient failed to report that her spouse was living in the assistance unit and his earned income and that two of her children, who had been included as members of the assistance unit, were not living with the recipient. DHS BOC calculated SNAP overpayments totaling \$23,541 for the period from January 2012 through March 2020.

**Failure To Report Household Composition (Case No. 1275866):** OIG conducted an eligibility investigation and found that, from September 2016 through July 2020, a SNAP recipient had failed to report that the father of her children was a part her household and earned wages. As a result, the recipient received an overpayment of \$32,101 in SNAP benefits.

**Failure To Report Responsible Relative (Case No. 1305420):** OIG conducted an eligibility investigation and found that, from October 2016 through June 2021, a SNAP recipient had failed to report that the father of her children was a part her household and earned wages, even though the father had resided in the home for years. As a result, the recipient received an overpayment of \$35,971 in SNAP benefits.

## Personal Assistant Investigations

**Personal Assistant Submitted Overlapping Timesheets (Case No. 1357602):** The Illinois Office of Executive Inspector General for the Agencies of the Illinois Governor (OEIG) investigated an allegation of time fraud against a state employee, who worked at DHS's Ludeman Developmental Center, as a Personal Assistant (PA) through DHS's Home Services Program (HSP), and as a Personal Support Worker (PSW) in DHS's Home-Based Support Services Program (HBS), and referred the matter to BOI. BOI, in turn, investigated the allegations for possible termination of the state employee as an enrolled Medicaid provider. OIG found that the employee's timesheets for their work at Ludeman, and as a PA and a PSW, overlapped on multiple occasions. OIG is pursuing terminating the employee as a Medicaid provider, and DHS recouped an overpayment of \$981.25 from the employee.

**Personal Assistant Billed for Services Not Performed (Case Nos. 1363303, 1364677):** OIG received a complaint from the Special Investigation Unit of Molina Healthcare that alleged that a PA had billed services while the client was admitted to a long-term-care facility. OIG confirmed that the PA had received \$18,931 in fraudulent payments for services that were not provided and referred the matter to the Medicaid Fraud Control Unit for criminal investigation.

## **2021 Statistics**

### ***Investigations Opened: 1,122***

Client-Eligibility Cases: **836**  
Provider Cases (Personal Assistants): **148**  
Prosecutions: **135**  
Childcare-Program Cases: **3**

### ***Investigations Completed: 1009***

Client-Eligibility Cases: **778**  
Prosecutions: **127**  
Provider Cases (Personal Assistants): **99**  
Childcare-Program Cases: **5**

## **Outcomes**

Client-Eligibility Cases  
    Founded: **519**  
    Unfounded: **259**

Provider Cases (Personal Assistants)  
    Closed: **78**  
    Referred to DHS for Action: **18**  
    Referred to law enforcement: **2**  
    Referred to OIG Legal for Administrative Action: **1**

Childcare-Program Cases  
    Founded: **3**  
    Unfounded: **2**

Prosecutions  
    Referred to Prosecutor: **6**  
    Conviction: **4**  
    Declined Prosecution: **7**  
    Insufficient Evidence to Refer for Prosecution: **110**

### ***Open Investigations: 1,783***

### ***Identified Overpayments***

Client-Eligibility Cases: **\$6,947,270**  
Childcare-Program Cases: **\$354,614** (\$328,764 provider, \$25,850 recipient)  
Established Restitution in Criminal Actions: **\$130,302**

## New Provider Verification and Monitoring

The New Provider Verification unit (NPV) reviews new applications, application modifications, and revalidations for all high-risk providers — transportation, durable medical equipment (DME), pharmacy with DME, home health — and any other providers of concern for issues such as past convictions or sanctions. NPV gathers and reviews additional information such as, background checks, licenses, insurance, and corporate records. NPV, after working with HFS Provider Enrollment Services and the applicant, makes a recommendation to OIG leadership as to whether to grant or deny the applicant's enrollment.

NPV continues to monitor new providers that are designated as high risk for fraud (based on their provider type) for one year after enrollment. Provider billing activities and claims are analyzed at several different periods during a provider's conditional enrollment, at 180 days and again just prior to their first year of enrollment. As a part of that process, the NPV analyst contacts the provider to offer guidance and answer any questions they may have regarding serving as a Medicaid provider. If no concerns are identified after a year of monitoring, then the provider becomes a fully enrolled Medicaid provider. If problems are identified, the matter is presented to OIG's Provider Review Committee, which may decide to extend the provider's conditional enrollment or to disenroll the provider.

### 2021 Highlights

**Expansion to include new provider monitoring:** In FY2021, NPV began the process of taking over provider monitoring during a new provider's conditional enrollment. This function was previously handled within the Bureau of Fraud Science and Technology. However, by taking over the monitoring responsibilities, NPV has been able to create efficiencies given the similarity with its existing functions related to new applicants.

### 2021 Statistics

#### **Reviews Conducted: 286**

New Applications Reviewed: **135**

Modifications Reviewed: **144**

Revalidation Applications Reviewed: **7**

#### **Review Outcomes**

New Applications

Approved: **110**

Denied: **23**

Withdrawn: **2**

**Modifications**Approved: **116**Denied: **28****Revalidations**Approved: **6**Denied: **1*****Providers Monitored During FY2021: 250***Monitoring Term Ended: **99**Enrolled: **85**Disenrolled: **14**Monitoring Term Ended: **151**

OIG and its state and federal partners “share responsibility for ensuring that state and federal dollars are used to deliver health care services consistent with efficiency, economy, and quality to eligible individuals and are not misused for fraud, waste, or abuse.” CMS Comprehensive Medicaid Integrity Plan for FY2019-2023.

## Supplemental Nutrition Assistance Program (SNAP) Fraud Unit

The SNAP Fraud Unit processes complaints against SNAP recipients who have participated in benefit trafficking schemes. The Unit also processes complaints on clients who do not follow the reporting guidelines of the program. Clients are required to report all household members, changes in income, verification of residency, along with several other requirements to determine eligibility. When clients fail to do so, the Unit will pursue appropriate disqualification measures. Recipients who intentionally violate SNAP rules and regulations are disqualified from the program for a period of twelve months for the first offense, twenty-four months for the second offense, and permanently for the third offense. Recipients who receive duplicative assistance or engage in trafficking are disqualified for ten years. Cost avoidance on SNAP cases is calculated based on the average amount of food-stamp standards during the overpayment period, multiplied by the length of the disqualification period. Unit staff represent the Department in DHS' Administrative Hearings to suspend subjects' benefits because of their abuse. OIG will transition this function to DHS in FY2022.

### 2021 Highlights

**Disqualification for Failure To Report Household Composition and Income (Case No. 1290650):** OIG processed a referral from DHS regarding a recipient who failed to disclose both a responsible relative's presence in the home and his earned income. After the recipient failed to sign a waiver voluntarily relinquishing eligibility, OIG referred the case to DHS for a disqualification hearing. At the hearing, SNAP Fraud staff presented evidence to establish that an overpayment of \$43,572 occurred resulting from fraud from October 2011 through October 2016 and the recipient was disqualified from the SNAP Program for twelve months.

**Disqualification for Trafficking SNAP Benefits (Case No. 1276235):** The federal Food and Nutrition Service referred an allegation of trafficking against an Illinois retailer. After a recipient who participated in the trafficking failed to sign a waiver voluntarily relinquishing eligibility, OIG referred the case to DHS for a disqualification hearing. At the hearing, SNAP Fraud staff successfully presented evidence establishing that the recipient had committed trafficking of benefits totaling \$2,626. The recipient was disqualified for twelve months as a result.

## **2021 Statistics**

***Referrals Received: 675***

***Case Reviews Completed: 260***

Cases Referred to Administrative Hearings: **83**

Resolved by waiver: **72**

Closed: **105**

***Responses to Law Enforcement Inquiries: 920***

***Disqualification Hearings Scheduled: 340***

***Disqualification Hearings Held: 320***

***Administrative Hearing Decisions Rendered: 141***

In favor of OIG: **130**

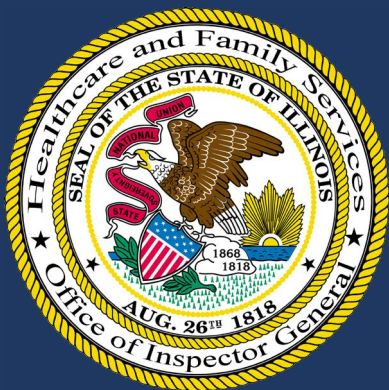
Not in favor of OIG: **11**

***Disqualified Recipients: 202***

***Identified Overpayment: \$655,954***

***Cost Avoidance: \$468,210***





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# **BUREAU OF INTERNAL AFFAIRS (BIA)**

The Bureau of Internal Affairs (BIA) investigates allegations of misconduct by HFS and Illinois Department on Aging. BIA also engages in proactive efforts to identify fraudulent staff activity and security weaknesses. BIA receives misconduct allegations from external sources and also identifies misconduct through proactive monitoring, and forensic reviews of Department computer equipment. BIA's investigative activities include preparing investigative reports and sharing the findings with the appropriate Department's division administrators, and coordinating investigations with state and federal authorities. Finally, BIA performs various security responsibilities for HFS, including monitoring the safety of employees and visitors in Department buildings; conducting background checks on new Department hires and staff who require access to Secretary of State data and/or federal tax information; granting and revoking facility access for employees and contractors; monitoring and reviewing security camera footage from the facilities; and conducting threat assessments for the Department. BIA serves as the Illinois Emergency Management Agency (IEMA) and State Emergency Operations Center (SEOC) liaison, coordinates emergency operation efforts, and communicates all pertinent information throughout HFS.

## 2021 Highlights

**Department on Aging Oversight:** In FY2021, BIA reestablished its investigatory jurisdiction over fraud, waste, abuse, mismanagement, and misconduct in the Department on Aging, including investigations of misconduct by that Department's employees, vendors, and contractors.

**Badging and Facility Access:** During FY2021, BIA issued new identification cards to 605 HFS employees and contractors for facility access.

**Background Checks:** During FY2021, BIA completed 480 background checks of HFS employees and applicants.

**COVID-19 Planning and Response:** Throughout the year, BIA continued to ensure HFS had safe working environments for staff to return to after months of remote work. BIA continued to work with IEMA and SEOC to gain personal protective equipment (PPE) for HFS staff, discuss emergency plans, and pass along guidance from daily briefings. BIA engaged in talks with Labor Relations and Personnel on how to make HFS work environments as safe as possible.

**Installation of Automated External Defibrillators:** This past year, BIA was involved in the procurement and installation of new Automated External Defibrillator (AED) units in HFS facilities throughout the state. The new AEDs can be used to help anyone who is experiencing sudden cardiac arrest. Once hooked up, the computer calculates whether defibrillation is needed. If so, voice prompts then guide individuals who lack medical experience through administering potentially life-saving external defibrillation.

**State Continuity of Operations Planning:** BIA has also been in the foreground of the development of the HFS Continuity of Operations Planning (COOP) document. The COOP plan establishes policy and guidance ensuring that critical functions continue, and that personnel and resources are relocated to an alternate facility in case of emergencies.

**LEADS Oversight:** BIA took ownership of the Illinois State Police Law Enforcement Agencies Data System (LEADS) for HFS. The new oversight and internal request procedures put in place not only removed accountability from other HFS areas but made the program simpler and more efficient.

## *Significant Investigations*

**Child Support Specialist Abuses Position:** In December 2020, BIA received a complaint alleging that an HFS Child Support Specialist had abused their position by accessing personal information about a client's child support case. The alleged access was an attempt to establish a personal relationship with the client through unwelcomed contact and quid pro quo harassment. BIA opened an investigation, established electronic monitoring by tracking the client's child support case, and interviewed the client in question. BIA obtained records of personal and inappropriate communication between the HFS employee and the client. It was determined that the Child Support Specialist violated conflict-of-interest rules, conducted themselves in a manner unbecoming an HFS employee, misused HFS computer systems, was non-cooperative with investigators, and violated sexual harassment policies. As a result of the investigation, the Child Support Specialist resigned in lieu of discharge with no reinstatement rights.

**Drug Use at Work:** In February 2021, BIA received a complaint alleging that drug residue and paraphernalia were found in a restroom of an HFS facility in Springfield. After BIA collected evidence, interviewed witnesses, and reviewed security camera footage from the facility, BIA established that a HFS Child Support Specialist II was using drugs at work. During the investigative interview, the subject admitted to regularly using illegal narcotics during the workday. As a result of the investigation, the Child Support Specialist II was suspended for twenty-nine days and agreed to enter a substance abuse program.

**Family Medical Leave Act Abuse:** In January 2018, BIA received a complaint alleging an HFS Human Services Caseworker had misused Family Medical Leave Act (FMLA) benefit time to attend a civil court hearing in December 2017. As a result of the allegation, BIA monitored the employee's civil court case from 2018 through 2020. BIA found that the employee abused their approved FMLA time on one occasion and sick time on six separate occasions to appear in court, totaling 40.25 hours. It was determined that the Human Services Caseworker falsified leave requests and abused both FMLA and sick time to attend court. As a result of the investigation the employee was given a five-day, unpaid suspension.

**Misuse of Government Resources and Sick-Leave Abuse:** In February 2020, BIA received a complaint alleging an HFS Accountant Advanced used an HFS printer to print personal items from the internet. As a result of the allegation, BIA seized the employee's State of Illinois computer and conducted a forensic examination of the computer's contents. BIA determined that the employee had saved or printed nonwork-related graphics, documents, and spreadsheets on

their work computer, and had used it to visit nonwork-related websites and send hundreds of personal emails. During the forensic review, BIA found that the employee had also committed eleven instances of sick time abuse. BIA determined that the Accountant Advanced violated rules of personal conduct and several policies related to use of the State of Illinois computer, email account, and sick leave. As a result of the investigation the employee was given a ten-day, unpaid suspension.

**Forgery:** In February 2020, BIA received a complaint alleging that an HFS Office Specialist submitted altered medical documents to HFS management to excuse an absence from work. BIA contacted the healthcare provider listed on the medical documents and established that the records had been altered. BIA interviewed the Office Specialist, and the Office Specialist provided false and inaccurate statements during the investigative interview. It was determined that the employee violated HFS policies by providing a falsified medical document and by providing false statements during the investigative interview. As a result of the investigation the employee was given a fifteen-day, unpaid suspension.

**Violation of Plea Agreement and Falsified Leave:** In September 2020, BIA performed a background check on an HFS Office Coordinator who was returning to HFS from another agency. During the background check, HFS learned of a previously undisclosed arrest. Based on documentation obtained from the arresting agency, the employee was arrested and issued citations for providing alcohol to a minor and for renting a hotel room for consumption of alcohol with a minor. Police reports reflect that there was a sexual encounter between the employee and a minor, however, related charges were not pursued as part of a plea deal. The employee pled guilty to providing alcohol to a minor and was placed on two years of court-mandated probation, including a mandated sexual-offender evaluation, prohibiting the employee from having any contact with minors. The Office Coordinator never notified HFS of the terms of his probation and continued to have direct contact with minors in violation of his probation. This matter was criminally referred to the Lake County Probation Office. In addition to the arrest, BIA determined that the Office Coordinator submitted falsified leave requests to use sick time to attend criminal-court hearings on at least six occasions. During the interview, the Office Coordinator admitted to violating HFS policies related to sick time use during the court dates. As a result of the investigation, the Office Coordinator resigned from their position at HFS.

## 2021 Statistics

### **Total Cases Opened: 515**

Misconduct Investigations: **34**

Background Investigations: **470**

Threat Assessments: **4**

Record Keeping: **7<sup>5</sup>**

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<sup>5</sup> Until April 2021, BIA classified cases that were closed not sustained after an initial investigation as "Record Keeping."

***Total Cases Completed: 524***

Misconduct Investigations: **31**

Background Investigations: **480**

Threat Assessments: **6**

Record Keeping: **7**

***Findings in Background Investigations***

Candidates Not Hired: **8**

Employees Disciplined/Resigned: **3**

***Outcomes in Substantiated Investigations***

Resignation/Termination: **4**

Suspension: **5**

Written Reprimand: **0**

No discipline: **4**

***Average Case Length***

Misconduct Investigations: **67 Days<sup>6</sup>**

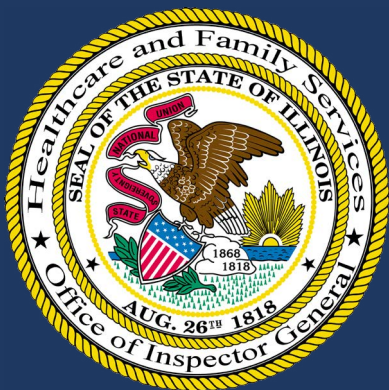
Background Investigations: **6 Days**

Threat Assessment: **7 Days**

Record Keeping: **16 Days**

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<sup>6</sup> The average duration of misconduct investigations excludes two cases that would misleadingly skew the average. One case was open for 998 days because the case was part of a civil lawsuit that delayed the closing of the BIA case, and a second case was open for 712 days because the subject of the investigation was on medical leave for an extended length of time. Including these two cases, the average duration of BIA misconduct cases was 118 days.



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# **BUREAU OF FRAUD SCIENCE AND TECHNOLOGY (BFST)**



# BFST Highlights

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## Fraud Science Team and Technology Management Unit

The Fraud Science Team (FST) and Technology Management Unit (TMU) of BFST develop fraud-detection routines to prevent and detect healthcare fraud, abuse, overpayments, and billing errors, and manage OIG's supporting IT infrastructure. The routines are analytical computer programs written in Statistical Analysis System (SAS) and Teradata SQL, utilizing HFS' Data Warehouse along with other third-party data sources. Examples of these analyses include:

- **Transportation and Psychotherapy Predictive Modeling:** BFST's transportation and psychotherapy predictive models allow increased efficiency in identification of potentially problematic health care providers. A risk score ranging between zero and one is assigned to each provider to reflect the potential risk of a provider being engaged in Medicaid fraud.
- **Opioid-Usage Dashboard:** BFST's opioid-dashboard module allows users to visualize usage trends of opioid-related drugs by morphine milligram equivalent level for the past five years. Management users tailor their views, which display payments, services, patients, and the number of involved pharmacies. The report provides a summary of opioid usage by prescriber, patient, and drug type. Different measures identify those at risk of opioid misuse or overdose.
- **Outlier Analysis — Provider Type Upstate/Downstate Analysis:** Provider Type Upstate/Downstate Analysis is an investigation of whether providers exceed the norm payment within their peer-provider type by geographic location (upstate and downstate). Standard deviations measure the amount of variation in the set of data values.
- **Outlier Analysis — Provider Type Cluster Analysis:** Outlier Analysis by Provider Type examines providers in relation to their cohort. Cohorts, in this analysis, are defined by geographic location and practice and payment patterns. Information is then clustered by merging neighboring counties after calculating average monthly payment values and the number of services, recipients, physicians, transportation providers, dentists, pharmacy providers, Durable Medical Equipment providers, and other providers in each county.
- **Outlier Analysis — Procedure-Code Analysis:** Procedure-Code Analysis compares the procedure-code payment and service distribution for the targeted provider with statewide averages. Ranking in the Procedure-Code Analysis represents the hierarchical order of individual providers within the same provider type. For this analysis, BFST uses the procedure code payment distribution discrepancy between the provider and statewide average for provider ranking and the size of a provider's payment. A higher rank for providers reflects a higher probability of fraud.
- **Post-Mortem Analysis:** BFST's Post-Mortem Analysis identifies claims of deceased recipients submitted by any provider type. Data sources used to validate recipient death information come

from the Illinois Department of Public Health, Enterprise Data Warehouse, the Centers for Medicare and Medicaid Services, and the U.S. Social Security Administration's death master file.

FST plans and implements the integration of sampling selection, audit reporting, systems integration, statistical validation, executive-information summaries, and other analyses that improve OIG's operational and decision-making processes.

TMU is responsible for all computer-related transactions within OIG, coordinating with the State's Department of Innovation & Technology (DoIT) on network access, and responding to hardware and software requests. Technology Management also handles web development, computer training, technical support, and database design and development, including testing and implementation of new features and software related to the Enterprise Data Warehouse (EDW) and the upcoming CORE claiming system. Finally, this section also completes data requests from federal, state, and local law enforcement agencies, many of which relate to cases which will result in dollars being returned to the State through court decisions and settlements.

## 2021 Highlights

**Dynamic Network Analysis (DNA) Updates:** FST oversees the development and maintenance of the Dynamic Network Analysis (DNA) system. OIG uses DNA's robust and comprehensive data analytics to help ensure Medicaid program integrity and compliance. Using DNA, BFST has developed various statistical models and routines to support detection of potential Medicaid fraud and abuse. In FY 2021 more than 9,300 reports were processed by the DNA framework system. The most common reports requested were recipient-claims details, recipient profiles, provider profiles, and marriage-divorce reports. In FY2021, BFST added new models to the DNA system to help identify and predict occurrences of fraud, waste, and abuse. For example, application of the time-series forecast model can predict the payments or services by geographical area, provider types, service categories, or procedure codes. Any outlier values, outside of the confidence interval in these categories, are identified for further evaluation and analysis. Various new report models were developed to enable retrieval of provider and/or recipient past service and payment information, including FFS/MCO payments, service counts, and recipient demographics.

**Provider Profile and Recipient Profile Data Expansion:** BFST's Provider Profile Report and Recipient Profile Report are the most complex and comprehensive reports generated by the DNA system. These reports serve as a "one-stop shop" for OIG staff's programmatic work, including audits, investigations, claim review, and peer review. The Provider Profile Report combines information from multiple data sources and applied statistical approaches for a targeted Medicaid provider. The Provider and Recipient Profile Reports are widely used in complaint analysis, responses to Federal requests, and ad hoc requests from various agencies.

In FY2021, BFST continued to analyze and organize data from the IMPACT system in DNA. Customized IMPACT information is made available on the DNA site through these efforts. By organizing this information in DNA, BFST ensures that information from IMPACT and the legacy systems is centrally aggregated in its profiles for use by all OIG bureaus. Currently, the data evaluated from IMPACT relates exclusively to provider enrollment. The IMPACT provider

enrollment system went into production in July 2015 and is considered the system of record. HFS is expanding IMPACT to serve as the complete information-management system for adjudicating claims processing and associated service reimbursement. Testing of new IMPACT components commenced in December 2021 and is scheduled to progress through 2022. Presently, IMPACT is scheduled to be used for claiming in 2024. OIG will continue to modify DNA with the expansion of IMPACT.

**Early Warning System Enhancements:** BFST's Early Warning System combines various critical indicators to identify exceptions to the norm and predict potential abuse and fraudulent activities by at-risk providers. The module uses the providers' billing and payment activities from the most recent five-year period. The early warning system is a proactive model that ranks providers for specific provider types in multi-dimensional views. This allows the user to scan providers and identify potential fraudulent targets. To define the at-risk severity of each provider, the model concentrates on providers with unusually high payments, volume of recipients, services compared to peers, value of common clients (provided services to the same recipients on the same day) compared to other providers, number of prescriptions involving controlled or narcotic drugs, and questionable procedure-code-billing patterns compared to their peers. The overall rank is generated based on these indicators. The higher the rank of the provider in the early warning system, the higher the need for further analysis.

Initially, the early warning model was designed for physicians, dentists, and optometrists. In FY2021, FST expanded the early warning model to additional practitioner types, including podiatrists, chiropractors, physical therapists, occupational therapists, speech therapists, and audiologists. As new statistical models and routines are developed and fully tested, they can be applied to additional provider types.

**DNA Fraud, Waste, and Abuse Executive (FAE) Report Implementation:** In FY2021, the FAE summary report was redeveloped to make it available, on-demand, to any DNA system user. This comprehensive report includes specific provider information including current enrollment status, summary of recent claim submission history, top-billed procedure codes, sanction-action history, National Provider Identifier (NPI) information, OIG case history, and applicable Billing Provider information.

**Sanction and IDFPR Inquiry:** The sanction inquiry was developed to extract sanction history from four specific federal and state-maintained data sources. Since key fields in the resources were not consistent, logic was implemented to ensure accuracy using matching sets of variables across the various data resources. The new inquiry allows users to enter various credentials for a comprehensive report, such as: Medicaid identification number, National Provider Identifier (NPI), professional license number, Social Security number, or business and individual names. The Illinois Department of Financial and Professional Regulation (IDFPR) inquiry provides a quick verification of individual or entity licensure status.

**Podiatry Fraud Analysis:** Following the Illinois Handbook for Providers of Podiatric Services, a few podiatry fraud schemes were evaluated and proposed by OIG auditors and investigators. The

DNA team explored all possible schemes and identified scenarios where potential overpayment was quantifiable. The top podiatrists, not following the billing and coding rules, were listed. An example where a podiatrist may be identified is when excessive “approved” routine foot care services were billed in less than a sixty-day interval, but approved services are only allowed every sixty-one days or longer.

**Ordering, Referring, Prescribing (ORP), and Rendering Report:** Typically, practitioners who order, refer, or prescribe will not be identified in claims-data reporting. Additionally, claims history will display the particular pharmacy receiving payment, but the desired reporting focus may be the drug prescriber. To assist auditors and investigators with obtaining a more comprehensive picture across service settings, the ORP and Rendering report was developed. This report will identify when specific practitioners appear across all four service areas. This data model supports a fuller investigation of the relationship among ordering, referring, prescribing, and rendering practitioners. This new module allows inquiry by NPI number, Medicaid ID, and includes the option of querying for one or more specific recipients.

## 2021 Statistics

***DNA Reports Generated: 9,137***

***DNA Pageviews: 19,441***

***Report Models Developed for Use: 68***

***Help Desk Inquiries: 3,335***

***Data Requests Completed: 46***

OIG leverages available data regarding the Medicaid program to ensure that it focuses its activities on matters with the potential for the highest return on investment.

## Provider Analysis Unit (PAU)/Recipient Analysis Unit (RAU)

In the PAU, nurses with clinical expertise analyze provider claims and records for indications of fraud, waste, or abuse. The nurse analysts conduct in-depth reviews of billing records to determine if claims and services are appropriate. They review billing patterns, research aberrant billing practices, determine business inter-relationships, and investigate suspicious pharmaceutical prescribing patterns. Upon completion, the analysts present their findings to OIG's Narrative Review Committee (NRC), which decides whether to start a criminal and/or administrative investigation for issues such as fraud in billing practices, risk of harm to patients, deficient quality of care, of-and/or- overprescribing. The NRC may decide to issue a letter of concern to the provider, outlining necessary corrective action; refer the provider within OIG to be audited, investigated or peer reviewed; or refer the provider to the Medicaid Fraud Control Unit. The NRC may also recommend referring the provider to external partners such as Illinois Medicaid Managed Care Organizations and the Illinois Department of Financial and Professional Regulation, or to the Office of Inspector General for the U.S. Department of Health and Human Services.

The RAU is composed of medical consultants who oversee the Recipient Restriction Program (RRP), which identifies, detects, and prevents abuse of medical and pharmaceutical benefits by recipients enrolled in Medicaid. The program assigns at-risk recipients to one Primary Care Physician, Primary Care Clinic, or Primary Care Pharmacy, so the recipient receives all medical care and coordination of their medical services by that primary provider, including referrals to specialists. Emergency and inpatient hospital services are not restricted. When recipients utilize multiple prescribing providers and multiple pharmacies they are at a significant risk for adverse and potentially lifethreatening situations. The RRP is designed to promote recipient safety through care coordination, often referred to as a "lock-in" or restriction program. The primary sources of identifying recipient overuse are the selection algorithm in the DNA system and external fraud and abuse complaints received by OIG.

### 2021 Highlights

**Transitioning Intake of MCO Referrals to Focus on Provider Reviews:** PAU was assigned to review all MCO fraud referrals sent to OIG to determine whether the unit would open a case based on the allegation. In FY2021, OIG began to transition this task to a centralized, interdisciplinary intake committee. This committee includes managers from various OIG units and it routes referrals directly to the appropriate OIG unit, not just PAU. As a result, referral decisions reflect the expertise from all areas of OIG; referrals are processed timelier, often within a week; and the outcomes rely on all of OIG's authority.

**Transitioning Monitoring of New Providers to New Provider Verification:** PAU was responsible for monitoring newly enrolled high-risk providers for their one-year, conditional enrollment period. This monitoring entails educating providers on specific rules and regulations, data analysis of submitted claims, and, at the end of a provider's conditional enrollment, recommending whether they should be enrolled, disenrolled, or extended as a conditional provider. In FY2021, OIG began the process of transitioning these activities to the Bureau of Investigation's New Provider Verification Unit, as this function aligns more closely with BOI's work than PAU's work. This

transition has allowed PAU to focus on provider reviews requiring the clinical knowledge and expertise of a nurse.

**Facility Medical Director Was Sanctioned Provider (Case No. 1341739):** PAU investigated a referral from a Medicaid MCO alleging that a community addiction facility was double billing, billing for services not provided, billing for unnecessary services, missing records, and cloning documentation. PAU's investigation revealed the physician listed as the facility Medical Director had been convicted on four counts of mail fraud related to the Medical Assistance Program and was terminated from the program many years before. The physician is a federally sanctioned provider according to the HHS exclusion list and cannot provide services in the Illinois Medicaid program. DHS, the administering agency for these community-based services, was notified of the exclusion rule and educated on the providers' need to check the exclusions list. The provider eventually replaced their medical director.

**Dental Provider Poses Risk of Harm (Case No. 1317597):** PAU investigated a referral from a Medicaid MCO alleging that a dental provider upcoded simple extractions to surgical extractions, billed for services not rendered, had an unlicensed person rendering care, was missing documentation, and had altered documentation. After substantiating some of the allegations based on a claims review, PAU referred the case to OIG's contracted dental broker for an immediate audit to assess for upcoding and billing for services not rendered; OIG was also asked to determine if unlicensed providers were performing services. The provider did not respond to repeated requests to submit records. OIG's dental broker sent the provider a finding-determination letter with overpayments for "failure to submit requested records" totaling \$32,176.15 for fee-for-service and \$38,078.96 for MCOs. The broker has offered a corrective active plan to the provider. If no response is received, the provider will be terminated from the program.

**Provider Prescribing Concerns, Loss of DEA License (Case No. 1333359):** HFS OIG's outside medical consultant referred an internal-medicine provider for review due to a dangerous prescription combination of opioids and benzodiazepines. PAU substantiated the allegations and presented its findings to the NRC, which, in turn recommended the provider be sent a letter of concern (1) outlining PAU's findings, and (2) highlighting CDC guidelines for safe prescribing of opiates and calculating morphine milligram equivalents (MME) of opioids, as well as the FDA Black Box warning regarding concurrent opiate and benzodiazepine use. The NRC also recommended that the provider be referred to the DEA and to the IDFPR for the identified prescribing concerns. The provider surrendered his DEA license after the DEA had closed its investigation, and IDFPR is now seeking to suspend the provider's medical license. This investigation also led to the separate referral of three recipients for lock-in evaluation in the RRP.

## 2021 Statistics

### PAU

#### **Cases Opened: 299**

From MCO Referrals: **256**

All Other Referrals: **43**

#### **Analyses Conducted: 359**

Cases presented to the Narrative Review Committee: **101**

Cases Unsubstantiated: **258**

#### **Outcomes from NRC: 101**

Referred to MFCU: **11**

Referred to Peer Review: **19**

Education to Provider: **15**

Policy Guidance: **5**

Quality-of-Care Concern: **10**

Referred to OIG Audit: **10**

Referred for External Audit: **10**

Follow-up Review in 24 Months: **3**

Termination from Medicaid Enrollment: **2**

No Action: **31**

### RAU

#### **Cases Reviewed: 1,011**

New Case: **872**

Re-evaluation after 12 months: **94**

Re-evaluation after 24 months: **45**

#### **Review Outcomes for 1,011 Cases**

Recommendations for Restrictions: **206**

Fee For Service Customer: **5**

MCO Customer: **201**

Cases Closed: **805**

No restriction Warranted: **737**

Restriction Released: **43**

Eligibility Cancelled: **7**

Deceased: **18**

#### **Total FFS Restrictions and MCO Restriction Recommendations at End of SFY2021: 353**

FFS: **143**

Twelve-Month Restrictions: **111**

Twenty-Four Month Restrictions: **32**

MCO: 210 Restriction Recommendations

#### **Cost Avoidance: \$1,462,941 (148 FFS recipients)**



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# **MANAGEMENT, RESEARCH, AND ANALYSIS SECTION (MRA)**



# MRA Highlights

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The Management, Research, and Analysis (MRA) Section serves as the liaison between OIG and all external partners. Specifically, the Fraud Abuse Executive (FAE) position coordinates all communication between OIG and law enforcement and works with the MCOs on data requests for criminal and civil investigations. The MRA Manager facilitates and oversees all communication regarding MCO audits, investigations, and other concerns related to fraud, waste, and abuse coming from the MCO Special Investigations Units, which are tasked with combating fraud, waste, and abuse in the Medicaid Managed Care plans.

The FAE coordinates the law enforcement data request program and assists with the review and approval of global settlement agreements generated by the National Association of Attorneys General, the Office of Inspector General for the U.S. Department of Health and Human Services (HHS-OIG), and the U.S. Department of Justice (USDOJ). OIG supports federal law enforcement and oversight counterparts including HHS-OIG, CMS, FBI, USDOJ, U.S. Attorney's Offices, and the National Association of Medicaid Fraud Control Units (NAMFCU).

The FAE monitors all actively pursued law enforcement cases and identifies key departmental staff members to provide expert-witness testimony at criminal and civil proceedings. Upon completion of the criminal or civil case, FAE coordinates internal administrative actions as necessary. Administrative actions can include audit reviews, PRU reviews, and administrative sanctions, including payment suspensions, overpayment recoupments, and termination from the Illinois Medicaid program.

In addition to working closely with law enforcement counterparts, the FAE is responsible for referring cases from OIG to other state and federal agencies. Referrals can be made to IDFPR, the Illinois Department of Public Health, DHS, CMS, HHS-OIG, and the DEA. These referrals can result from Audit, PRU, or PAU cases, in which provider education, licensing concerns, or billing concerns have been identified.

## 2021 Highlights

**Office-Wide Training:** MRA facilitates training sessions for OIG staff to improve their knowledge base and skill sets. In FY2021, OIG's participation in national collaborative learning sessions increased by expanding the offerings to all levels of OIG staff. The Public Health Emergency has allowed for more training opportunities for webinars and teleconferences. Collaboration among sister agencies as well as national anti-fraud counterparts, like the National Health Care Anti-Fraud Association and the Healthcare Fraud Prevention Partnership, has allowed access to free educational tools and resources for OIG auditors, investigators, and data-analytics staff.

**Inter-Agency Collaboration on Substance Abuse Providers:** During clinical and data reviews, OIG staff have identified concerns in billing and prescribing by providers approved

by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) under their DATA 2000 program. These “data waived” providers are qualified practitioners, certified to prescribe buprenorphine, a medication approved by the Food and Drug Administration (FDA) to treat opioid-use disorders. These providers receive a waiver to administer, dispense, and prescribe buprenorphine from SAMHSA. In FY2021, to promote cross training and subject-matter expertise on this topic, OIG contributed to a collaborative training organized with DHS’ Division of Substance Use Prevention and Recovery (SUPR), MFCU, MCO Special Investigative Units (SIUs), and other stakeholders. The program, entitled “HFS-OIG Collaborative Cross-training: SUPR Program, Fraud, Waste, and Abuse, and Data 2000 Waived Providers,” brought together subject-matter experts to discuss issues and concerns regarding the program, including potential fraud schemes. This collaboration allowed for an open discussion among the 100 program stakeholders in attendance on billing standards, policies, fraud schemes, and legal limitations regarding criminal and civil investigations.

## 2021 Statistics

### ***Referrals to External Partners: 108***

MFCU: **19**

Accepted: **14**

Not Accepted: **5**

Other State and Federal Government: **89**

### ***Responses to Data Requests: 71***

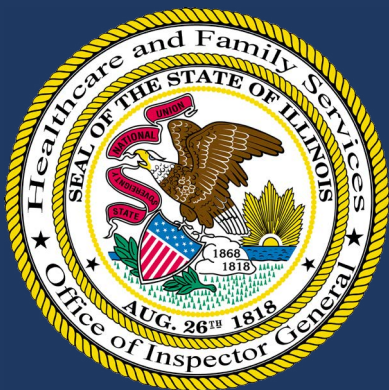
Law-Enforcement Data Requests: **50**

MCO data requests: **21**

### ***Global Settlements: 5***

### ***Provider Referred to OCIG for Termination from Medicaid: 37***

### ***Office-Wide Trainings: 31***



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# **OFFICE OF COUNSEL TO THE INSPECTOR GENERAL (OCIG)**



# OCIG Highlights

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OIG attorneys in the Office of Counsel to the Inspector General (OCIG) represent HFS in administrative hearings relating to Medicaid fraud, waste, and abuse cases that result in provider terminations, financial recoveries, payment suspensions, and application denials. They also handle any resulting negotiations of settlements and corporate-integrity agreements. OCIG further supports OIG operations, including researching termination/exclusion issues, analyzing extrapolation issues, reviewing contracts, assisting with rule and statute changes affecting the agency, and offering compliance advice and representation on HFS programs and operations. OCIG provides dedicated support to Peer Review, the Medical Quality Review Committee (MQRC), the Long-Term Care – Asset-Discovery Unit, and OIG’s Medicaid Recovery Audit Contractor. OCIG also handles all Freedom of Information Act (FOIA) requests, subpoenas, and litigation matters.

## 2021 Highlights

**Recovery Audit Contractor (RAC) Initiative:** Under the stewardship of OCIG, the RAC program-integrity oversight initiatives flourished in FY2021. Designated RAC attorneys coordinated efforts with external and internal partners to streamline the RAC audit and recovery process, including identification and collection of outstanding audit claims pursuant to provider-agreement and administrative-recovery actions. Additionally, OCIG RAC attorneys have ensured program-integrity compliance in the identification of emergent trends and implementation of recommendation of policy updates following changes promulgated by CMS, the National Correct Coding Initiative (NCCI), NCCI Procedure to Procedure Edits, Current Procedural Terminology (CPT), and the Healthcare Common Procedure Coding System, all consistent with Illinois’ Medicaid billing requirements. RAC program recoveries for FY2021 totaled \$5,200,781. Recoveries included payments-in-full pursuant to provider agreements, recoveries approved by the HFS Director pursuant to a final administrative decision, and settlements. Recoveries involved both automated audits and complex audits including utilization review of complex claims, diagnostic-related groups, CPT codes, durable-medical equipment and long-term-care facility credit balances of current and former Medicaid residents. OCIG attorneys handled several significant RAC recovery cases, including:

**\$1,840,196.74 from Long-term Care Facility:** OIG resolved twelve pending matters against a long-term-care facility that stemmed from audits by OIG’s Recovery Audit Contractor and contracted CPA firms. The audits identified billing issues related to credit balances for recipients currently residing in the facility, discharged recipients, and deceased recipients. The provider agreed to repay HFS \$1,840,196.74, resolving these matters before they went to a hearing.

**\$48,000 from Billing Code and Documentation Review:** OIG negotiated a settlement with a physician provider for \$48,000 in lieu of an administrative recoupment action seeking

recovery of \$68,455.44. The settlement encompassed the audit period of February 1, 2012, through August 31, 2014. The audit findings included various errors in billing for CPT codes and noncompliance with documentation of the medical records.

**\$15,812.13 from Hospital Utilization Review:** OIG negotiated a settlement agreement with a hospital provider for \$15,812.13 in lieu of an administrative recoupment action seeking to recover \$22,588.75. The settlement encompasses a RAC audit of two individual claims of service for inpatient stays in April 2016 for \$5,228.43 and September 2017 for \$10,583.70. RAC determined that, based upon a utilization review, these claims neither met the state's objective standard of InterQual Criteria, nor rose to the level of an inpatient stay based upon a clinical physician review. It was determined that these services could be effectively furnished more economically on an outpatient basis or inpatient healthcare facility of a different kind.

**\$13,282.18 from Hospital Utilization Review:** OIG negotiated a settlement with a hospital provider for \$13,282.18 in lieu of an administrative recoupment action seeking to recover \$18,974.55. The settlement encompasses a RAC audit of two individual claims of service for inpatient stays in September 2016 and August 2017. RAC determined that, based upon a utilization review, these claims neither met the State's objective standard of InterQual Criteria nor rose to the level of an inpatient stay based upon a clinical-physician review. It was determined that these services could be effectively furnished more economically on an outpatient basis or inpatient healthcare facility of a different kind.

**Review of Backlogged Personal Assistant Applications:** In FY2021, while administrative hearings were paused due to COVID precautions, OCIG attorneys undertook an intensive review of criminal backgrounds for over 700 personal assistants whose services did not qualify for Federal Financial Participation (FFP) because their applications had not been properly vetted during the State's switch to an automated application process. OCIG attorneys reviewed each record and recommended that some applications be rejected for disqualifying convictions, but recommended approval for applications without disqualifying convictions. Based on the review and approval of applications, the State has been able to access \$2,375,115 in FFP.

## ***Provider Termination and Financial Recovery***

**\$1,181,537.43 Overpayment *In re Everlast Transportation Inc., Case No. 12 MVH 104:*** OIG filed a recovery and termination notice against transportation provider, Everlast Transportation, Inc., based on OIG audit findings that the provider had failed to keep records required by program regulations. The audit established an \$1,181,537.43 overpayment. After an evidentiary hearing, the administrative law judge agreed that Everlast had failed to keep the required records and issued a recommended decision that the Department recover \$1,181,537.43, terminate the company as a Medicaid provider, and bar its owner from further participation in the Medicaid program. In February 2021, the HFS Director issued a final administrative decision agreeing with the termination and recovery.

**\$259,406.41 Overpayment *In re Jose Thomas, M.D., Case No. 09 MVH 128:*** An OIG audit and re-audit established that the provider had over 2,500 improper claims due to billing for non-covered

service, missing records, and missing documentation for specific services. OIG filed notice to recoup an extrapolated overpayment of \$259,406.41 and to terminate the provider. After a hearing was completed, the administrative law judge recommended that HFS receive the full recovery and terminate the provider and the HFS Director agreed.

**\$454,325.31 Overpayment *In re Karen Taylor, M.D., Case No. 12 MVH 132*:** OIG filed a recovery and termination notice against Dr. Karen Taylor as the result of an OIG audit of group-psychiatric services billed. The provider failed to provide records for a large number of the services billed. At her hearing, the provider argued that a management company had maintained the records and she should not be held responsible. The administrative law judge who heard the case found that, as an enrolled provider in the Medicaid program, the doctor was required to maintain records, and that her failure to provide those records formed the basis for the recoupment and termination. In March 2021, the HFS Director issued a final administrative decision to terminate the provider from the Medicaid program and recover the \$454,325.31 overpayment.

**\$124,975.91 Overpayment *In re Zlatoia Savici, M.D., Case No. 09 MVH 127*:** An OIG audit established that the provider had thousands of improper claims due to missing records, billing for non-covered services, lack of documentation to support specific services, and the use of improper procedure codes. OIG filed a notice to recover \$124,975.91 and suspend the provider from the Medicaid program. The administrative law judge issued a recommended decision establishing the overpayment and suspending the provider; the HFS Director affirmed that decision.

**\$4,158.47 Overpayment *In re Now Medical Transportation, Case No. 20 MVH 047*:** In October 2016, after hearings in three cases regarding billing discrepancies that were identified during OIG audits, the non-emergency transportation provider was ordered to repay HFS \$4,158.47. The provider failed to repay the Department. In response, OIG filed an action to terminate the provider and bar the owner from the Medicaid program. The administrative law judge issued a recommended decision agreeing with OIG and the HFS Director affirmed that decision.

**\$6,934.04 Overpayment *In re Always on Time, LLC, Case No. 19 MVH 129*:** In May 2017, after a hearing regarding billing discrepancies, the provider was ordered to repay HFS \$6,934.04. After the provider failed to repay that amount, OIG filed an action to terminate the provider and bar the owners. The administrative law judge issued a recommended decision agreeing with OIG and the HFS Director affirmed that decision.

## ***Provider Terminations***

***In re Maher Dalati, M.D., Case No. 20 MVH 017*:** IDFPR suspended Dr. Dalati's medical license because the provider had engaged in sexually inappropriate conduct with a seven-year-old patient. OIG immediately suspended the provider and filed a notice seeking to terminate him from the Medicaid program. After the provider failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, OIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Shaun A. Kink, M.D., Case No. 20 MVH 026:*** IDFPR suspended Dr. Shaun Kink's medical license because he had engaged in sexually inappropriate conduct with a patient. OIG proceeded to file an immediate suspension-and-termination action. After the provider failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, OIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Shaku Chhabria, M.D., Case No. 17 MVH 159;***

***In re Munavvar Izhar, M.D., Case No. 20 MVH 107;***

***In re Syed Akhter, M.D., Case No. 20 MVH 106;***

***In re Thomas Tilot, M.D., Case No. 20 MVH 077;***

***In re Carlos Rafael Da Fonseca, M.D., Case No. 20 MVH 075:*** In each of these cases, IDFPR suspended the physician's medical license due to inappropriate controlled-substance prescriptions, which constituted an immediate danger to the public. As a result, OIG proceeded to file immediate suspension-and-termination actions. When the providers failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, OIG asked the administrative law judge to issue default-and-recommended decisions to terminate them from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendations.

***In re Nicholas Recchia, M.D., Case No. 20 MVH 046;***

***In re Angela Tanney, LPT, Case No. 19 MVH 105;***

***In re Michael Zahra, M.D., Case No. 20 MVH 079;***

***In re Melissa Y. Smith, APN/RN, Case No. 20 MVH 085:*** In each of these cases, IDFPR suspended the licensed healthcare professional due to substance abuse, which constituted an immediate danger to the public. As a result, in each case, OIG immediately suspended the provider and filed a notice seeking to terminate him or her from the Medicaid program. When the providers failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, OIG asked the administrative law judge to issue default-and-recommended decisions to terminate them from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendations.

***In re Andrew Mueller, APN/RN, Case No. 20 MVH 081;***

***In re Erin Kinder APN/RN, Case No. 20 MVH 080:*** In these cases, IDFPR suspended the healthcare professional's nursing license due to drug diversion, which constituted an immediate danger to the public. In each case, OIG proceeded to file an immediate suspension-and-termination action. After the providers failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, OIG asked the administrative law judge to issue default-and-recommended decisions to terminate them from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendations.

***In re George Gekas, D.D.S., Case No. 19 MVH 066:*** IDFPR suspended Dr. Gekas's dental license due to physical and mental impairment, which constituted an immediate danger to the public. OIG proceeded to file an immediate suspension-and-termination action. After the provider failed to request

a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, OIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Spiros G. Stamelos, M.D., Case No. 19 MVH 093:*** IDFPR suspended Dr. Stamelos's medical license due to his failure to disclose a disciplinary sanction. OIG proceeded to file an immediate suspension-and-termination action. After the provider failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, OIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re John Alexander Sandoval, M.D., Case No. 20 MVH 078:*** IDFPR suspended Dr. Sandoval's medical license because he was charged with committing a forcible felony, which constituted an immediate danger to the public. OIG immediately suspended the provider and filed a notice seeking to terminate him from the Medicaid program. After the provider failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, OIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Stephen Perns, DPM, Case No. 20 MVH 083:*** IDFPR suspended Dr. Perns's podiatry license because he relinquished his podiatry license for podiatric malpractice, which constituted an immediate danger to the public. OIG immediately suspended the provider and filed a notice seeking to terminate him from the Medicaid program. After the provider failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, OIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Lee Bee, D.O., Case No. 20 MVH 074:*** IDFPR suspended Bee's medical license due to distributing unused and/or expired medications to his patients, which constituted an immediate danger to the public. OIG proceeded to file an immediate suspension-and-termination action. After the provider failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, OIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Augusto Chavez, M.D., Case No. 20 MVH 073:*** IDFPR suspended Dr. Chavez's medical license because his medical privileges were summarily suspended. OIG immediately suspended the provider and filed a notice seeking to terminate him from the Medicaid program. After the provider failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, OIG asked the administrative law judge to issue a default-and-recommended

decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Steven Matthew Dzyban, APN/RPN, Case No. 20 MVH 009:*** IDFPR suspended Matthew Dzyban's nursing licenses due to his failure to report professional discipline that had been imposed on him in Tennessee. OIG proceeded to file an immediate suspension-and-termination action. After the provider failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, OIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Tele Okubanjio Ekundayo, PT, Case No. 20 MVH 076:*** IDFPR suspended Tele Okubanjio Ekundayo's physical-therapy license because of billing inaccuracies for physical-therapy services. OIG immediately suspended the provider and filed a notice seeking to terminate him from the Medicaid program. After the provider failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, OIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Terrence J. Hall, M.D., Case No. 20 MVH 084:*** IDFPR suspended Dr. Hall's medical license because the provider voluntarily surrendered his medical licenses in California and Oregon. OIG immediately suspended the provider and filed a notice seeking to terminate him from the Medicaid program. After the provider failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, OIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Octavio Cardona-Loya, M.D., Case No. 20 MVH 087:*** IDFPR suspended Dr. Cardona-Loya's medical license because the provider voluntarily surrendered his medical license in California. OIG immediately suspended the provider and filed a notice seeking to terminate him from the Medicaid program. After the provider failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, OIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Michael R. Kinney, M.D., Case No. 20 MVH 091:*** IDFPR suspended Dr. Kinney's medical license due to his failure to notify the DEA of a pending IDFPR disciplinary action. OIG proceeded to file an immediate suspension-and-termination action. After the provider failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, OIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Gregory Randle, M.D., Case No. 19 MVH 105:*** IDFPR suspended Dr. Randle's medical license due to his failure to pay income taxes. OIG immediately suspended the provider and filed a notice

seeking to terminate him from the Medicaid program. After the provider failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, OIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Tracy Otis, Case No. 20 MVH 119:*** OIG filed a notice seeking to terminate Tracy Otis, a personal assistant, who improperly billed the State \$14,690.13 for home-based services to a Medicaid recipient during hours when the provider was incarcerated. After the provider failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, OIG asked the administrative law judge to issue a default-and-recommended decision to terminate her from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Mitchell Dampier, Case No. 19 MVH 5024:*** OIG filed a notice seeking to terminate Mitchell Dampier, a personal assistant, who had been convicted of felony offenses in the State of Illinois. The provider also made a materially false statement on his Medicaid provider enrollment form by asserting that he had never had a criminal conviction when, in fact, he had at least one. Additionally, the provider improperly billed the state \$2,267.61 for home-based services to a Medicaid recipient during hours when the recipient was in a hospital or long-term-care facility, and not at home. After the provider failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, OIG asked the administrative law judge to issue a default -and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Christopher Bonner, Case No. 19 MVH 5022:*** OIG filed a notice seeking to terminate Christopher Bonner, a personal assistant, who had been convicted of felony offenses. The Provider also made a materially false statement on his Medicaid provider enrollment form by asserting that he had never had a criminal conviction when, in fact, he had at least one. Additionally, the provider improperly billed the state \$1,138.93 for home-based services to a Medicaid recipient during hours when the Provider was incarcerated. After the provider failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, OIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Ashley Barrett, Case No. 20 MVH 108:*** OIG filed a notice seeking to terminate Ashley Barrett, a personal assistant, who improperly billed the state \$1,233.24 for home-based services to a Medicaid recipient during hours when the recipient was in a hospital or long-term-care facility, and not at home. After the provider failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, OIG asked the administrative law judge to issue a default-and-recommended decision to terminate her from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Roshunda Haynes, Case No. 20 MVH 110:*** OIG filed a notice seeking to terminate Roshunda Hayes, a personal assistant, who improperly billed the state \$1,130.14 for services to a Medicaid recipient during hours when the provider was working at a secondary place of employment. After the provider failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, OIG asked the administrative law judge to issue a default-and-recommended decision to terminate her from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Juanita Hodge, Case No. 20 MVH 117:*** OIG filed a notice seeking to terminate Juanita Hodge, a personal assistant, who improperly billed the state \$1,148.03 for home-based services to a Medicaid recipient during hours when the recipient was in a hospital or long-term-care facility, and not at home. After the provider failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, OIG asked the administrative law judge to issue a default-and-recommended decision to terminate her from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

## ***Financial Recoveries***

***Recoupment of \$159,904 Repaid after Provider Termination:*** In October 2017, the HFS Director issued a final administrative decision concluding that Dr. Al Qawasmi Fouad owed the Department \$159,904.90 based on various OIG audit findings, including missing records, billing for improper procedure codes, and billing for unauthorized services. Despite the 2017 administrative order, the provider did not repay the overpayment, forcing OIG to file another action in FY2020 for termination for nonpayment. In April 2021, a final administrative decision was issued terminating the provider. Shortly thereafter, the provider repaid the amount owed in full and then filed an administrative review action. In light of the provider's full and immediate payment, OIG agreed to have the final administrative decision terminating the provider withdrawn.

***Recoupment of \$8,938.76 from Transportation Provider:*** OIG filed a notice seeking to recoup an overpayment of \$8,938.76 from a transportation provider following an OIG desk audit for the audit period of May 1, 2009, through December 31, 2013. After the provider failed to retain counsel and appear at a scheduled administrative status hearing, the ALJ granted HFS OIG's motion for default. The recommended decision was later affirmed by the HFS Director.

***Settlement of \$4,000 from Transportation Provider:*** An OIG audit established hundreds of instances of improper billing for services while a recipient was in a facility, billing for loaded mileage against program rules, and duplicate billing. OIG filed a notice for recoupment and termination. To settle the matter, the provider agreed to repay \$4,000 prior to the commencement of a hearing.

## ***Enrollment Denial***

***In re LM Paratransit, Case No. 19 MVH 007:*** OIG successfully prevented LM Paratransit from enrolling in the Medicaid program. The sole owner of the applicant, Ayodele Agunbiade, had been the sole owner of Amegrow Incorporated, which had been terminated in September 2008 from the Medicaid program due to extensive auditing discrepancies. At that time, the owner was barred from the program and ordered to pay HFS a recoupment amount of \$285,435.35, which he has failed to pay. Despite

this history, the owner has made several attempts to re-enroll in the program under different company names.

## **2021 Statistics**

### ***Cases Filed: 78***

Enrollment Denials: **4**

Terminations: **58**

Overpayment Recoupments: **16**

OIG Audit Recoupments: **3**

RAC Audit Recoupments: **13**

### ***Final Actions: 197***

Termination Decisions: **110**

Suspensions: **1**

Overpayment Recoupment: **77**

Barrment: **19**

### ***Reinstatement Actions: 24***

Denied Applications: **3**

Reinstatement Cases: **7**

Disenrollment Cases: **14**

### ***Payment Withholds: 8***

### ***Corporate Integrity Agreements***

Entered: **6**

Monitored: **13**

Ended: **2**



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# **FISCAL MANAGEMENT UNIT**

# Fiscal Management Highlights

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The Fiscal Management Unit is made up of Budget, General Collections, Bad Debt Recovery and Procurement. The Fiscal Management Unit maintains and updates OIG's Operations Budget and handles OIG's procurements and intergovernmental-agency agreements. It processes and tracks overpayments established as a result of OIG audits of Medicaid providers, provider settlements, global settlements, and court-ordered restitutions. The Fiscal Management Unit establishes accounts receivable for all finalized overpayments and monitors these accounts until the debts are collected. If a debt is determined to be uncollectable, the uncollected debt case is forwarded to Bad Debt Recovery, which works with the Office of the Illinois Attorney General and the HFS Director's Office to enact and manage the State's process for writing off an uncollectable debt.

## 2021 Highlights

**Budget:** OIG's FY2021 Operations budget was \$4.1 million. General Revenue Fund expenditures constituted 4.05% of this amount, while Part F – Public Aid Recoveries Trust Fund expenditures totaled 95.95%. The breakout of the Operations budget is as follows (percentages are based upon the total Operations budget):

- 58% Health Management Services (HMS), which serves as the OIG's Recovery Audit Contractor vendor.
- 27% Other professional contracts, such as the OIG contract with Northern Illinois University, court-reporting and audio-transcription services, fingerprinting and background check services, public-records-access and-search services, various personal-services contracts.
- 10% Twenty-eight medical and one statistical contracted consultants.
- 03% Other professional expenses, such as contractual reimbursement for nurse and attorney licenses; subscriptions to program-integrity associations; petty cash; copy and photo services; medical, healthcare-coding, and employee book purchases; and reimbursement to employees for conference fees.
- 01% Employee and consultant travel.
- 0.4% Equipment for specialized services that are not part of the HFS Administrative Services or the Department of Innovative Technology (DoIT) budget.

**Collections:** The OIG Collections unit handles cases that have resulted in either a final audit determination, a final administrative determination, a provider-settlement agreement, a global settlement agreement or a client-restitution agreement. Once an overpayment is finalized, Collections staff will establish an account receivable for the amount owed to HFS. When a provider fails to make a payment, the Collections staff will send the provider an initial payment-reminder letter. If the provider does not comply with initial reminder letter, the collections staff send the provider a fifteen-day demand letter. If the provider does not comply with the fifteen-day demand letter, the accounts are sent to Bad Debt Recovery and to OIG legal staff for termination and barrment of the provider from the Medicaid program. The debt will then be processed by the Fiscal Management Unit's Bad Debt Recovery staff. In FY2021, Collections processed and maintained approximately 656 accounts receivables. In FY2021, OIG collections by Audit Type and Provider Type were as follows:

### ***Audit Type***

RAC Audits – **54.46%**

Field Audits – **37.21%**

Self-Disclosure Audits – **7.12%**

Desk Audits – **1.20%**

Other Audits – Civil Remedy and PERM - **0.01%**

### ***Provider Type***

Long Term Care Audits – **57.04%**

Hospital Audits – **31.01%**

Physician Audits – **4.48%**

Pharmacy Audits – **3.55%**

Other Practitioners – **2.67%**

Transportation Audits – **1.25%**

**Demand Letters:** In FY2021, the Fiscal Management Unit sent out fifteen-day demand letters in 124 non-RAC-related audits. Fifty-six percent of the letters were sent to transportation providers. In response to these letters, the Fiscal Management Unit collected \$341,500. Providers owing collectively over \$15 million in debt were sent to OCIG for program termination and barrment proceedings due to nonpayment.

**Bad Debt:** When the Fiscal Management Unit has exhausted all attempts at collection and a debt is still outstanding, OIG seeks to have the debt deemed uncollectible. Staff in Fiscal's Bad Debt Recovery Unit determine whether the case will go to an outside collection agency, to the HFS Director's office for write-off, or to the Attorney General's Office for write-off. This determination depends on various factors, including whether the providers or owners have assets and income to cover the debt owed to the Department. A recently finalized bad debt case includes:

**Physician Overpayment of \$249,347:** OIG audited physician Jonathan Annis and established a \$249,347 overpayment. After an administrative hearing, an Administrative Law Judge upheld the finding. The Collections unit was provided a final administrative decision and collection proceedings commenced. The Department was able to recover \$130,048.40 from the provider before he stopped making payments. OIG referred the case to the Attorney General's Office, which approved the write-off of the remaining \$119,299 in debt. The provider is no longer practicing medicine in Illinois.

**Transportation Overpayment of \$254,975:** OIG conducted an audit of transportation provider, MCS Medical Transportation, and identified an overpayment of \$254,975. The total overpayment identified was comprised of three different types of transportation audits:

1. \$228,955.66 based upon an extrapolated field audit;
2. \$22,698.67 based upon identification of billings for transportation during an inpatient stay, duplicate billings, and improper billings for loaded mileage; and
3. \$3,321.21 based upon identification of billings for transportation during an inpatient stay, and improper billings for loaded mileage for a second audit period.

The corporation did not respond to the final audit determination and OCIG initiated an administrative recovery action. The owner of the corporation filed for personal bankruptcy but did not file bankruptcy for the corporation, therefore collection efforts proceeded. As the provider was non-cooperative, the matter proceeded to an administrative hearing and the administrative law judge's recommended decision established that the provider owed \$254,975. The bulk of this debt was deemed uncollectible by the Attorney General's Office on November 18, 2021.

**Transportation Overpayment for \$610,433:** OIG performed an audit on Medicare transportation company, Sunshine Express Transportation Service, and identified an overpayment of \$610,433.75. After an administrative hearing, an administrative law judge found in favor of the Department. During the administrative proceedings, the Department held claims that the provider had submitted. The Department released and applied these claims to the provider's debt, resulting in a \$15,307 collection. The Fiscal Management Unit submitted the remainder of the debt to the Attorney General's Office for write-off. The Attorney General's Office approved the \$595,125 write-off on January 4, 2021.

**Procurement:** The Fiscal Management Unit processed thirty-seven contracts, two amendments, and two intergovernmental agency agreements during FY2021. These included contracts for OIG's medical and statistical consultants; court-reporting and audio-transcription services; and background check and record-search services. The Fiscal Management Unit also helps to oversee OIG's fourteen existing intergovernmental agreements with federal, state, and municipal partners.

## 2021 Statistics

### Procurement

Contracts: **37**

Value of Contracts: **\$3,082,798**

Interagency Agreements: **14**

Value of Interagency Agreements: **\$700,000**

***Collections***

Account Receivables: 1,402

New Account Receivables: 1,342

Outstanding Account Receivables: 260

Value of New Account Receivables Established: \$15,650,205

Collected Account Receivables: \$12,613,691

Open Account Receivables: \$50,001,431

***Bad Debt***

Bad Debt Cases Established: 7

Value of Established Bad Debt Cases: \$2,283,540

Cases Sent to Collection Agency: 82

Value of Cases Sent to Collection Agency: \$1,947,276.24

Total Bad Debt Cases Written Off: 70

Value of Bad Debt Cases Written Off: \$885,899

While OIG has the authority to recover overpayments, it continuously seeks to strengthen methods to prevent fraud and abuse in the Medicaid program so that improper payments are not made in the first instance.



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# **MANAGED CARE ORGANIZATIONS (MCOs)**

# MCO Program Integrity Results

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Illinois' Medicaid managed care program, HealthChoice Illinois, had six contracted Managed Care Organizations (MCOs) at the end of FY2021. These were Aetna, Blue Cross, Meridian, Molina, CountyCare, and Humana (Medicare-Medicaid Alignment Initiative Plan only). These organizations are statutorily and contractually obligated to operate program-integrity units to identify fraud, waste, and abuse and they report the results of their activities to OIG on a quarterly basis. OIG reviews the MCOs' referrals of potential fraud to determine whether further activity is warranted and provides the authority for MCOs to move forward with overpayment recoveries from Medicaid providers. The results of the MCO's activities in FY2021 were as follows.

## **2021 Statistics**

***MCO Audits and Investigations: 990***

***MCO Program-Integrity Actions: 256***

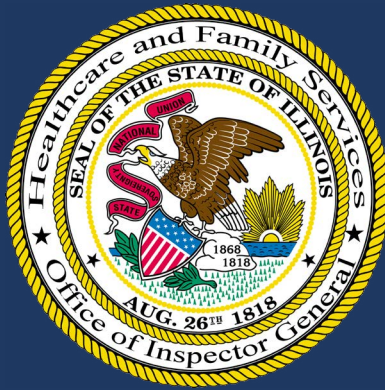
***MCO Member Lock-Ins: 3,735***

***MCO Identified Overpayments: \$8,240,594***

***MCO Collected Overpayments: \$2,063,119***

***MCO Fraud Referrals to OIG: 374***

As managed care is now the predominant payment model for Medicaid, it is imperative that OIG monitor and collaborate with Illinois' MCOs to ensure fiscal transparency; prevent fraud, waste, and abuse; and promote high-quality care.



## OFFICE OF INSPECTOR GENERAL

### Illinois Department of Healthcare and Family Services

## Annual Report FY2021

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